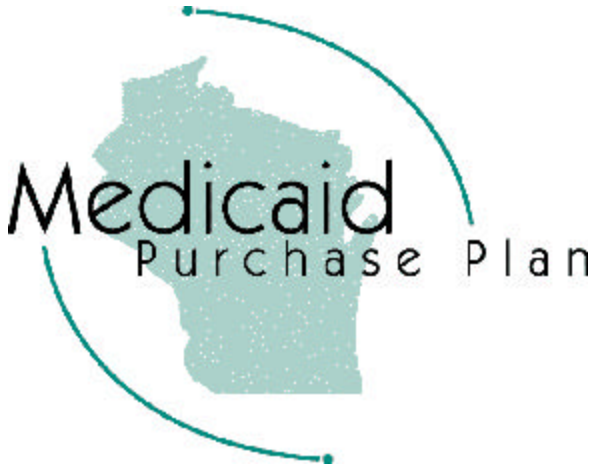
Medicaid Purchase Plan Evaluation
Annual Report



for

Center for Delivery Systems Development
and the Division of Health Care Financing
Department of Health and Family Services

August 15, 2001

Submitted by:
Innovative Resource Group, LLC
Madison, Wisconsin

Table of Contents

I. EXECUTIVE SUMMARY 1

II. BACKGROUND 4

EVALUATION CONTRACT 4
EVALUATION COMPONENTS 4

III. PROGRAM OVERVIEW 6

PROGRAM GOALS 6
ELIGIBILITY CRITERIA 6
PROGRAM FEATURES 6
HEALTH CARE COVERAGE 7
PREMIUMS REQUIREMENTS 7

IV. IMPACT EVALUATION 9

ENROLLMENT TRENDS 9
DEMOGRAPHIC DATA 10
PREMIUM STATUS 11
MEDICAID AND MAPP 13
WAIVER STATUS 13
HEC ENROLLMENT 14
INDEPENDENCE ACCOUNTS 15
MRE AND IRWES 15
THIRD-PARTY LIABILITY 16

V. FISCAL EVALUATION 17

VI. PROCESS EVALUATION 22

STATE AND COUNTY ADMINISTRATION ISSUES 22
SUBMISSION OF MAPP ELIGIBILITY FORMS 24
PREMIUM CALCULATIONS 26
PREMIUM STRUCTURE 28
LOCAL PERSPECTIVES 30
TELEPHONE SURVEY RESPONSES 31
PTI BENEFIT SPECIALIST COMMENTS 31
OTHER COUNTY COMMENTS 33
HEC PROGRAM IMPROVEMENTS 34

VII. SUMMARY 37

VIII. APPENDIX 39

ATTACHMENT A: PREMIUM SCHEDULE 39
ATTACHMENT B: ELIGIBILITY TRENDS FOR MAPP ENROLLEES 40
ATTACHMENT C: NEW ENROLLMENT AND DISENROLLMENT BY MONTH 41
ATTACHMENT D: CUMULATIVE ENROLLMENT VS. CURRENT ENROLLMENT BY MONTH 42
ATTACHMENT E: COUNTY BREAKDOWN OF DISABLED MEDICAID ENROLLEES VERSUS MAPP ENROLLEES 43
ATTACHMENT F: MAPP ENROLLMENT BY PREMIUM STATUS 45
ATTACHMENT G: MAPP PREMIUM PAYMENT HISTORY 46
ATTACHMENT H: WAIVER STATUS OF MAPP ENROLLEES, DECEMBER 2000 AND APRIL 2001 47
ATTACHMENT I: WAIVER STATUS OF MAPP ENROLLEES 48
ATTACHMENT J: WAIVER STATUS OF MAPP ENROLLEES WITH MULTIPLE WAIVERS 49
ATTACHMENT K: JOB GOALS FROM HEC EMPLOYMENT PLANS 50

ATTACHMENT L: MAPP APPLICATION WORKSHEETS 51
ATTACHMENT M: SUMMARY OF RETURNED MAPP APPLICATIONS BY COUNTY 59
ATTACHMENT N: SUMMARY OF COUNTY TELEPHONE INTERVIEWS 61
ATTACHMENT O: MAPP EVALUATION SURVEY ADMINISTRATION AND METHOD 64

I. Executive Summary

The Department of Health and Family Services, Center for Delivery System Development contracted with Innovative Resource Group to conduct an evaluation of the Wisconsin Medicaid Purchase Plan (MAPP). MAPP was created by Wisconsin Act 9 and was implemented on March 15, 2000. MAPP provides Medicaid coverage to individuals with disabilities whose family income is below 250% of the federal poverty level (FPL).

This report summarizes the research and findings of the first year of the evaluation (through June 30, 2001). The evaluation has three components: (1) impact, (2) process and (3) fiscal. The impact evaluation will examine the effect of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The process evaluation will determine if the program was implemented equitably across the state and whether the program is efficient and effective. The fiscal evaluation will monitor the effects of MAPP on state, federal and local Medicaid and long-term care funding.

At this early stage in the evaluation there is insufficient data to report on many of the impact outcomes. Therefore, this report emphasizes findings related to the process aspect of the evaluation as information on the implementation and administration of the program was more readily available. The report also provides baseline demographic data on the MAPP population and includes a preliminary analysis of MAPP enrollees' health care costs and utilization. Finally, the report provides data on the health care costs and utilization of the MAPP population.

Initially, enrollment in MAPP was modest, but by the end of the first year of the program over 1,300 individuals had been enrolled for some period of time. At the end of the first year (March 2001), there were 1,200 current eligibles in the program. MAPP is a statewide program and nearly all of Wisconsin's 72 counties have enrolled at least one individual in the program. The majority of MAPP participants are between the ages of 35 and 64 with very few participants below the age of 25 or over the age of 65. The population is 55% male and 45% female. Over 60% had been enrolled in Medicaid in the month prior to MAPP enrollment and almost 86% had been enrolled in Medicaid at some point in time prior to their MAPP enrollment. The vast majority of enrollees are also eligible for Medicare.

Individuals whose income is over 150% of the FPL are required to pay a premium to participate in MAPP. Based on Medicaid eligibility data, from July 1, 2000 through June 30, 2001, just over 18% of the eligibles were required to pay a premium. During that time period, monthly premiums ranged from $10 to $675. All premium collections for the year generated $191,555 in revenue for the program. For an average month during the year, premium payments were equal to approximately 3.7% of total paid claims for that month.

Since the programs inception, an increasing number of MAPP participants have been receiving health care services. In the first quarter of the program 77% of the participants utilized at least one health care service as compared to 95% in the quarter ending June 30,

2001. For state fiscal year 2000-01 (July 1, 2000 through June 30, 2001) total Medicaid benefit expenditures on behalf of MAPP participants were almost $5.3 million. Over one-half of all benefit costs were for prescription drugs.

The MAPP program was implemented without making changes to the Client Assistance Re-Employment and Economic System (CARES), which is the automated system used by counties to determine eligibility for Medicaid and other public assistance programs. Consequently, MAPP eligibility is determined through a manual process of completing paper application forms. It is expected at the time of this writing that MAPP will be automated on CARES in the late fall of 2001.

Manual MAPP eligibility determinations contributed to a number of process issues during the first year of the program. For example, there is evidence that county economic support (ES) workers did not consistently complete the application forms properly, resulting in incorrect eligibility determinations and premium calculations. In addition, the Center for Delivery System Development (CDSD) was reliant on counties to submit the paper forms in order to obtain information to be used for monitoring and evaluating the program. Counties have submitted applications for approximately 56% of the enrollees to date, thereby limiting the ability to effectively monitor and evaluate the program.

Anecdotal feedback from county staff and Pathways to Independence (PTI) Benefit Specialists also suggests that MAPP was implemented with varying degrees of success across the state. In some counties, particularly Milwaukee County, potential MAPP applicants are reported to have had difficulties accessing the program because county ES workers did not understand the program eligibility requirements or were unavailable to process an application. PTI Benefit Specialists have also suggested that the existing work exemption policies are not well suited for the disabled population and may function as a barrier to enrollment. County staff have also identified a need for additional outreach to identify and enroll more people who may be eligible for the program.

An analysis of MAPP applications has also illustrated that the program's current premium structure has been inequitable in its administration. Again, as a result of the manual eligibility determination process, ES workers have incorrectly calculated the premium for a number of MAPP enrollees across the state. Consequently, some individuals who should have been paying a premium to participate in MAPP were not. MAPP applicants whose income exceeds 150% of the FPL are expected to contribute 3% of their adjusted earned income and 100% of their countable unearned income toward their premiums. In actuality, depending on which ES worker processed their application, some recipients with income over 150% of the FPL have been receiving benefits without paying a premium.

Three MAPP surveys developed specifically for the evaluation are currently in the field-two recipient surveys and a disenrollee survey. The surveys will provide more detailed information than is available from existing administrative databases. Specifically, the surveys will capture changes in income, savings and health status among the MAPP

population over the course of the evaluation. The survey will also be a measure of program satisfaction. A fourth, ES worker survey, is approved and awaiting implementation. This survey is intended to measure ES worker's understanding of the MAPP program and their experience with its implementation. To date the recipient surveys have achieved a 34% response rate. Data from the MAPP surveys will be reported in year two of the evaluation.

While it is too soon to measure the impact of MAPP on participants' ability to earn more money without fear of losing health insurance and to save toward independence it appears that the program is on track toward meeting these goals. The fact that the majority of MAPP enrollees were previously receiving Medicaid coverage through non-MAPP eligibility criteria, suggests that MAPP has allowed some Medicaid recipients to earn more or retain higher assets without fear of losing their Medicaid coverage.

The third goal of the program – to offer an effective, efficient and equitable program has been more of a challenge over the last year. While some of the factors contributing to the inefficient and inequitable aspects of the program will be resolved with CARES automation, a number of policy modifications that would further improve the program are included as recommendations in the report.

II. Background

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level ($25,770 in 2001 for an individual). In Wisconsin, this subprogram is called the Medicaid Purchase Plan (MAPP). MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000.

Evaluation Contract

Under a contract with the Department of Health and Family Services, (DHFS) Center for Delivery System Development (CDSD), Innovative Resource Group (IRG) is conducting an evaluation of MAPP. IRG offers diversified health care consulting services, specializing in decision support services, data analysis and reporting, program evaluation and other technical health care services. IRG is conducting the evaluation in partnership with The Management Group (TMG) and Electronic Data Systems (EDS). TMG is a management consulting and services organization with experience in health and long-term care. EDS is the Wisconsin Medicaid fiscal agent and specializes in data warehousing and data management.

The request for proposal (RFP) was for a three year evaluation of MAPP. The original contract was from May 1, 2000 through June 30, 2001. Based upon satisfactory performance and the continued availability of funding, the contract is eligible for up to two one-year renewals. The contract was recently renewed for year two of the evaluation (July 1, 2001 through June 30, 2002). The final year of the evaluation would be from July 1, 2002 through June 30, 2003. This annual report covers the program from its inception (March 15, 2000) through the end of the first contract year.

As required under the contract, the IRG-team has developed a MAPP Business Objects Universe, which resides on the Medicaid Evaluation and Decision Support (MEDS) data warehouse. This universe brings together the data necessary to complete the analytic tasks of the evaluation. The universe leverages data from the existing MEDS data warehouse, such as Medicaid eligibility and claims information, but it also incorporates new "external" data such as recipient survey results and MAPP eligibility worksheets. As a result of the manual MAPP eligibility process, it was necessary to develop a MAPP application database to capture data from the paper MAPP application. An Access application database was developed and data from this database is routinely downloaded to the MAPP universe.

Evaluation Components

The MAPP evaluation has three components: impact, process and fiscal. The impact evaluation will examine the effects of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The process evaluation will determine if the program was implemented equitably across the state and whether the program is efficient and effective. It will also measure participant satisfaction through recipient and disenrollee surveys. Finally, the fiscal evaluation will monitor the effects of MAPP on

state and federal Medicaid funding and will examine the effects of MAPP on locally funded long-term care services.

III. Program Overview

Program goals

The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Eligibility Criteria

In order to be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years old. They must be determined as disabled by the Department of Health and Family Services (DHFS), Disability Determination Bureau (DDB). Recipients must also be working or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under $15,000. Countable assets include items such as cash savings, life insurance policies, stocks and bonds, but do not include an individual's home or vehicle.

Program Features

In addition to providing health care coverage, the MAPP program includes a number of features designed to foster independence.

Enrollment in the HEC program provides individuals an opportunity to enroll in MAPP to secure health care coverage, while seeking employment. Enrollment in the HEC program temporarily fulfills the MAPP work requirement by requiring development of an employment plan consisting of benefit counseling, employment barriers assessment, and a plan to address all identified barriers to employment. Upon approval of the employment plan, the MAPP work requirement is waived and the applicant becomes eligible for the MAPP program for at least nine months, with the possibility of a three-month extension if necessary. If the enrollee remains unemployed after the three-month extension, he/she loses MAPP program eligibility. The HEC program is administered by Employment Resources, Inc. (ERI) under contract with the CDSD.

Once enrolled in MAPP, recipients can establish "Independence Accounts", which are intended to foster savings for items that increase personal and financial independence. By establishing an Independence Account, MAPP recipients can save earnings above the $15,000 countable asset limit for the program. Total annual deposits to Independence Accounts can not exceed 50% of gross earned income each year.

MAPP policies include a work exemption provision for individuals who are sick and need to take off of work for a period of time. Recipients who have participated in MAPP for at least six months are eligible for the exemption. The exemption itself can last up to six months and is limited to two exemptions every three years.

Health Care Coverage

The MAPP program offers health care coverage to eligible individuals. Family coverage is not available. However, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

MAPP recipients are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL). Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Premiums Requirements

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals would be counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income.

Unearned income includes Social Security benefits, disability benefits and pensions. Adjusted unearned income equals total unearned income less the following deductions:

- Standard living allowance ($634 per month for calendar year 2001)
- Impairment-related work expenses (IRWEs), such as work space modifications
- Medical and remedial expenses (MREs), such as attendant care

Earned income is income from paid or self-employment. Adjusted earned income equals gross earned income before taxes and any remaining income deductions from one's unearned income. In other words, if one's unearned income is less than the sum of the allowable deductions, the difference can be applied as a deduction to one's earned income.

Premium income is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives a $850 monthly SSDI payment and earns $1,200 per month. He spends $50 a month on cab fare to work and has $10 in medical payments per month.

Calculation of Monthly Premium

Monthly Unearned Income =	$ 850
Less Standard Living Allowance	*$ 634*
Less IRWEs	*$ 50*
Less MREs	*$ 10*
Adjusted Unearned Income	**$ 156**
Monthly Earned Income=	$1,200
Less Remaining Deductions	*$ 0*
Adjusted Earned Income	***$1,200***
	x .03
	$ 36
	+ 156
Premium Income	$ 192
Premium Amount[1]	$ 175

[1] Premium income between $175 and $200 results in a premium of $175. A premium Schedule is included as attachment A in section VIII Appendix.

IV. Impact Evaluation

The purpose of the impact evaluation is to measure the impact of MAPP on participants' ability to earn more and save toward their independence while retaining their health care coverage. In addition, the impact evaluation will track participants' health status and health care utilization over time.

Information for the impact evaluation will be drawn from a number of sources including the:

- MAPP application
- Recipient surveys
- Disenrollee surveys,
- Medicaid eligibility
- Claims data
- Data from the Human Services Reporting System (HSRS)
- Other data as available

The majority of the impact analysis will be conducted during years two and three of the evaluation to allow for the compilation of sufficient data to conduct trend and impact analyses.

At this time, the ability to report baseline demographic data on the MAPP population is limited by the fact that 44% of the MAPP applications have not been submitted to the Center for Delivery Systems Development. Consequently, the annual report focuses primarily on characteristics, which are discernable from information collected through the Medicaid Management Information System (MMIS) and from the CDSD's HEC tracking database.[2]

Enrollment Trends

While enrollment in the program was modest for the first three months of operation, it grew dramatically over the next nine months. From March through May 2000, an average of 46 new individuals were enrolled in the program each month. In the subsequent nine months of the year, new monthly enrollment averaged 118 individuals. In the first year of the program, cumulative enrollment was over 1,300 individuals (active enrollment in March of 2001 was approximately 1,200 individuals). Please see Attachment B, C and D in section VIII Appendix for month by month summaries of enrollment, disenrollment and pre and post MAPP Medicaid eligibility periods.

A large percentage of the MAPP participants accessed the program through Dane County Human Services. Individuals enrolled for MAPP by Dane County comprise 13.2% of the total MAPP population. MAPP enrollments are also concentrated in Milwaukee County (4.8%), Marathon County (4.7%), Winnebago County (4.7%), and Outagamie County (4.4%). These five counties are also in the top ten counties for disability-related

[2] Application submission rates were calculated by comparing the social security numbers of individuals identified as MAPP eligible in MMIS with the individuals in the MAPP application database.

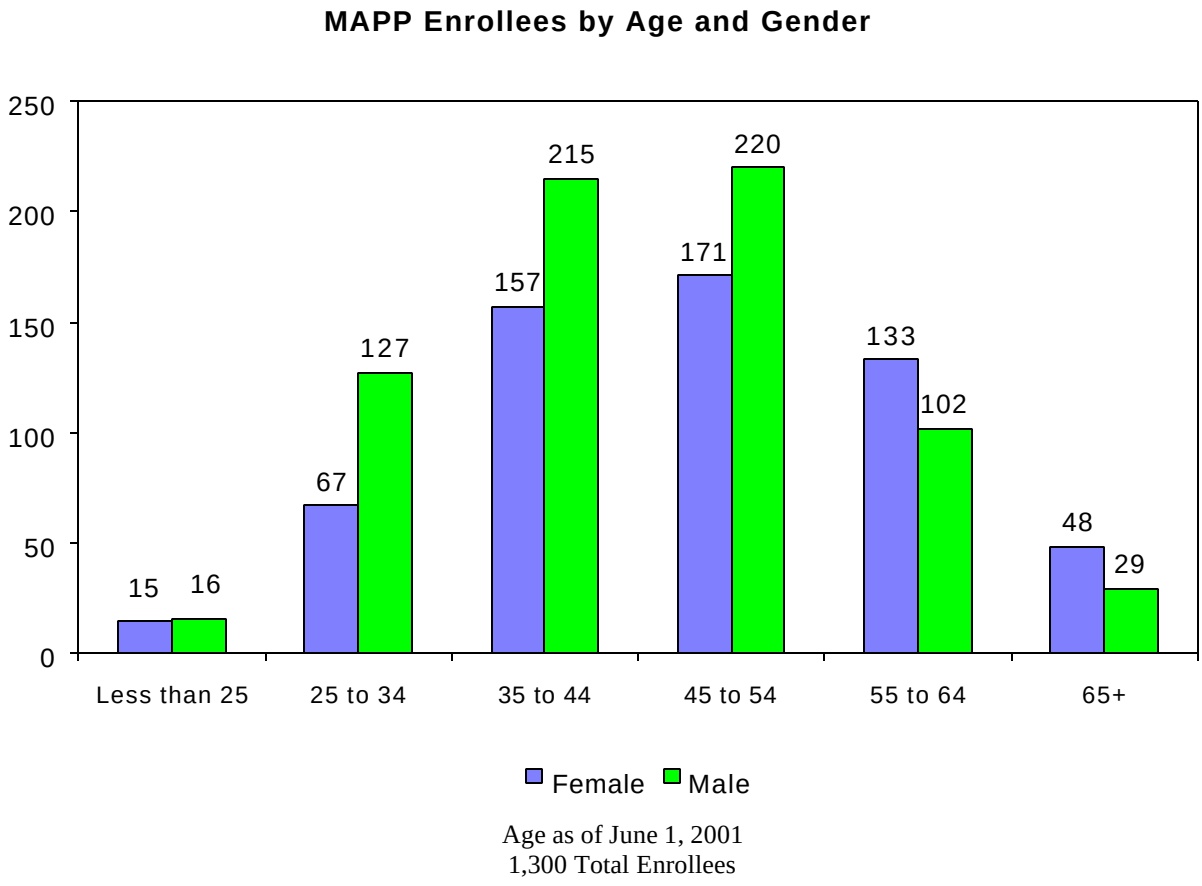
Medicaid enrollments based on an analysis of Medicaid medical status codes. Milwaukee County has enrolled approximately 28.9% of the disability-related Medicaid population; followed by Dane County at 5.6%.

Given their proportion of the disability-related Medicaid caseload, one might expect Milwaukee to be the leader in enrolling individuals for MAPP. The fact that Dane County has certified more than 2.5 times the number of people as Milwaukee might indicate a problem with access or another system issue in Milwaukee County. Information gathered from Pathways to Independence Benefits Specialists (see section VI Process Evaluation for more detail) does, in fact, suggest that there have been some challenges with program implementation in Milwaukee. This situation will continue to be monitored in year two of the evaluation.

Attachment E in section VIII Appendix provides a full listing of MAPP and disability-related Medicaid certifications by county.

Demographic Data

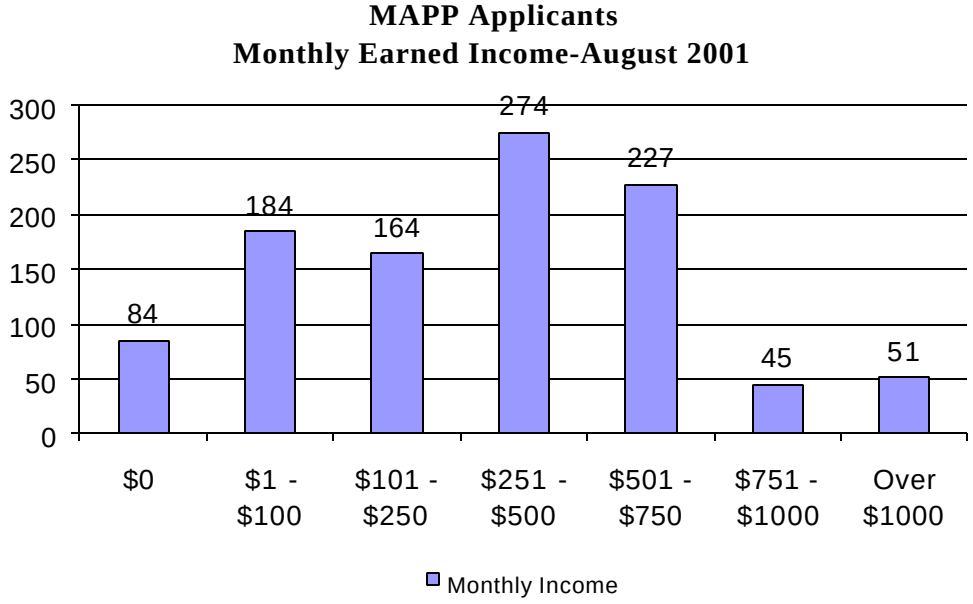
As of June 1, 2001, there were 1,300 current MAPP eligibles. The following chart provides a breakout of the population by age and gender.



Age as of June 1, 2001
1,300 Total Enrollees

As the chart illustrates, almost 60% of the participants are between the ages of 35 and 54 and the population is 55% male. The proportion of men and women varies within each of the age categories, with the most disproportionate ratio being among the 25 to 34 year-olds, which are 65% male. In the over age 65 category, 62% of the participants are female.

According to the application data, MAPP applicants reported earned income ranging from $0 to $3,998 per month with an average of $393.[3] Reported assets ranged from $0 to $15,000 with an average of $1,995. The following table shows the distribution of these enrollees by the amount of their monthy earned income



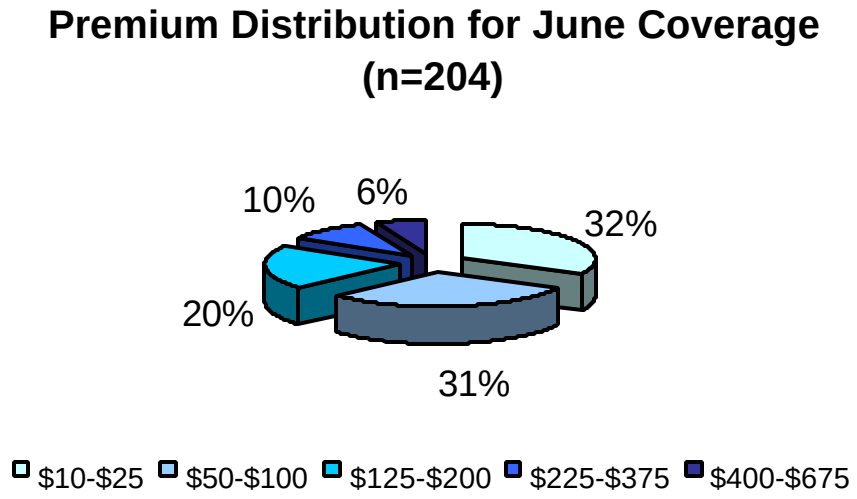
Source: MAPP Application Database
Note: Data represent 1,029 individuals with a MAPP application on file with CDSD and it includes individuals who did not subsequently enroll in MAPP. It does not include individuals who enrolled in MAPP, but have not had their application submitted to CDSD by the county.

Premium Status

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL) for their family size are subject to a premium. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data (i.e. medical status codes), the percentage of MAPP participants paying a premium averaged 18.3% per month for state fiscal year (SFY) 2000-01. The lowest month was July 2000 (16%) and the highest month was April 2001 (19.8%). Attachment F in section VIII Appendix provides a monthly summary of MAPP enrollment by premium status.

[3] These figures do not represent the entire universe of MAPP enrollees. They represent individuals with an application on file with CDSD, including applicants who did not subsequently enroll in MAPP. Income and asset figures reflect amounts reported at the time of application.

The amount of the MAPP premium varies dramatically among participants. For the June 2001 benefit month, premiums ranged from $10 to $675.[4] Of the 204[5] individuals paying premiums for June coverage, 32% were paying a $10 or $25 premium. Another 31% were paying a premium between $50 and $100 and 20% were paying between $125 and $200.[6] The remaining 17% pay premiums in excess of $200 per month. Of these, there are 13 individuals paying a monthly premium in excess of $400. The average premium for the month of June was $120.88. See the graph below for a summary of premium payment amounts.



For SFY 2000-01, MAPP premiums have generated $191,555 in revenues offsetting the costs of the program directly and indirectly. Premium payments may be used as the state match to claim federal funds for Medicaid costs. For state fiscal year 2000-01, the federal share of these costs was 59.16%. Therefore, the $191,555 in premium revenues collected that year generated an additional $277,445 in federal funds. In total, premium payments generated $469,000 of non-state revenues to offset program costs. For an average month during that period, premium payments were equal to approximately 3.7% of the total claims paid for the month. Attachment G in section VIII Appendix provides a month by month summary of premium and claims payments for SFY 2000-01.

[4] In June there were 8 individuals who had incorrectly paid a $10 premium, letters were sent to these individuals in July. Per a change in MAPP policy effective October 2000, $10 premiums for MAPP are waived. Consequently, the lowest premium amount required is $25 (see section VI Process Evaluation for additional detail on this issue).

[5] The number of individuals paying a premium for a given month may be different than the number of individuals with a premium medical status code for that month due to lags in payment, non-payment of premiums or coding errors.

[6] The premium schedule is set at increments of $25. For example, premiums are $25, $50, $75, etc.

Medicaid and MAPP

The vast majority of MAPP participants were Medicaid eligible prior to their enrollment in MAPP. Of the 1,525 individuals who were eligible for MAPP between January 2000[7] and June 2001, 929 (61%) were enrolled in Medicaid in the month prior to their MAPP enrollment. Just over 1,300 (86%) were enrolled in Medicaid at some point in time prior to their MAPP enrollment. Since its inception, there have been 299 individuals who have disenrolled from MAPP at least once. A proportion of the individuals who disenroll from the program subsequently re-enroll in non-MAPP Medicaid. A total of 198 individuals have had at least one post-MAPP Medicaid eligibility segment for the same time period.[8] The vast majority of the non-MAPP Medicaid eligibility segments were SSI-related, as illustrated in the following table.

MEDICAL STATUS GROUPS	# EX-MAPP ENROLLEES
SSI-Related	122
Medicare Beneficiaries	25
SSI	18
Waiver	16
BadgerCare	9
Nursing Home	6
Healthy Start	2
Total	**198**

Waiver Status

A small percentage of MAPP enrollees are also participating in a community based long-term care program. Waiver status for a MAPP enrollee was identified through the Human Services Reporting System (HSRS), long-term care module. Data in this system is collected from individual counties. Counties are required to submit HSRS data annually, on a calendar year basis, but they may voluntarily submit data on a monthly basis. Consequently, December 2000 is the most complete month of data available at this time.

In December 2000, 13% of the MAPP participants were matched to HSRS waiver data for that month. Approximately 60% of these individuals were participating in either the Community Options Program (COP) or in the Community Integration Program (CIP). Almost 30% of the MAPP community based program participants were enrolled in COP regular (COP-R). Another 30% were enrolled in CIP 1B (locally matched slots). Less than 10% of the individuals were participating in the COP waiver (COP-W) program.

[7] While MAPP began in March of 2000, there were a number of individuals who had their initial eligibility backdated to January 2000. Under Medicaid policy, eligibility can be backdated three months from application if the individual would have met all eligibility criteria for those months.

[8] Please note that an individual may have more than one disenrollment and more than one post-MAPP eligibility segment. For example, as a result of changing income, a participant could have disenrolled from MAPP in February 2001; been on SSI-related Medicaid in March and April; re-enrolled in MAPP for May and June; disenrolled from MAPP and became eligible for non-MAPP Medicaid a second time.

COP-R is supported entirely with state funds and there are a number of restrictions on how these funds can be used for individuals who are also eligible for community based waiver programs, such as COP-W and CIP. The ability to convert individuals from COP-R to COP-W is a matter of fiscal importance to the state because COP-W services are eligible for federal Medicaid match, while COP-R services are not. It was expected that through MAPP eligibility requirements some COP-R participants would be eligible for and converted to the COP-W program. The number of MAPP COP-R participants suggests that counties may not be converting MAPP recipients from COP-R to COP-W. There are a number of reasons that counties may not be able to complete these conversions. For example, COP-R participants who are chronically mentally ill or who have Alzheimer's disease are not eligible for Medicaid waiver services, including COP-W. There are also services available under COP-R that are not available under COP-W. In year 2 of the evaluation, it is hoped that additional information on MAPP participant's diagnoses will be available to better understand this issue.

Attachment H, I and J in section VIII Appendix provide additional detail on the waiver status of MAPP enrollees.

HEC Enrollment

At the end of June 2001, there were 35 MAPP recipients, representing 27 counties, enrolled in the HEC program. Each of these individuals identified at least one job goal on his/her employment plan. The employment plan provides space for four job goals and most applicants identified more than one. These goals were recorded in the CDSD HEC tracking database. The top three listed job categories were: (1) computer and general office work, (2) assembly or manufacturing work; and (3) janitorial or maintenance work. Attachment K in section VIII Appendix summarizes the full listing of job categories.

The HEC employment plan also provides insight into the barriers these individuals face as they seek employment. A review of the 35 plans found a total of 140 barriers (some duplicative) listed. Common barriers included: lack of skills, transportation problems, stress, prior work history, medication side effects, other physical/mental symptoms associated with their disability and the need for special accommodation, including flexible scheduling.

Attempts to match information from the HEC tracking database[9] with the MAPP application database have raised some questions about the administration of the HEC component of the program. There are 84 individuals in the MAPP application database who have enrolled in MAPP and reported $0 in earned income. Using $0 of earned income as a proxy for employment status, one would expect the majority of these individuals to be enrolled in HEC. However, only ten of the 84 individuals are on file as having enrolled in HEC. It may be that $0 in earned income is not a reliable proxy for employment status (e.g. some of these individuals are "working", but do not have any countable earned income for MAPP) or it may be that there are individuals enrolled in MAPP who are neither working nor enrolled in HEC. HEC enrollment will continue to be tracked as more of the MAPP applications are filed with the state.

[9] Only 33 of 35 HEC participants had a social security number on file to be matched.

Independence Accounts

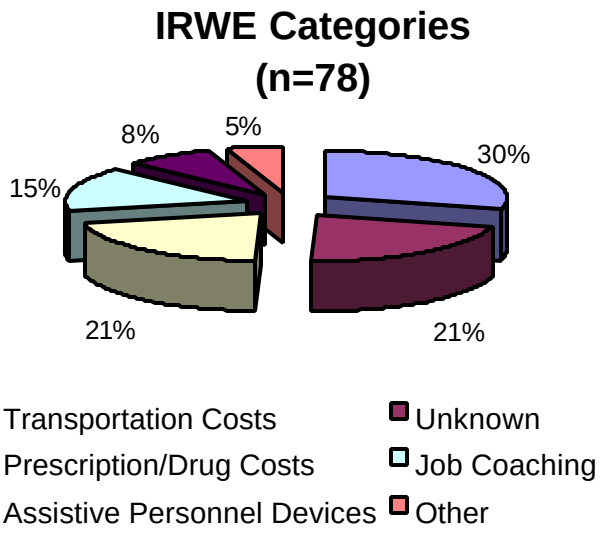
To date, 31 Independence Account registrations (representing 19 individuals) have been sent to the state. This low number of registrations (only 1% of the MAPP eligible population) suggests one of three things: (1) participants are not taking advantage of this program benefit; (2) participants are not aware of this program benefit; or (3) Economic Support (ES) workers are not submitting the registrations to the state. A better understanding of this phenomena will be sought in years two and three of the evaluation.

The majority of the registered accounts, approximately 55%, are retirement accounts. Nearly all the remaining accounts can be divided equally into three categories: checking accounts, savings accounts, and money market/CD accounts. Two accounts could not be categorized. The average registered balance in the accounts is $3,896. The lowest balance is $210 and the highest is $13,900. Five accounts have a registered balance in excess of $10,000.

MRE and IRWEs

MAPP participants are eligible to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and Medical Related Expenses (MRE) for the purpose of calculating premiums amounts. Information on MREs and IRWEs[10] is collected by ES Workers as part of the MAPP application process. Therefore, our analysis of these expenses is limited to the individuals who have a MAPP application on file with the CDSD (approximately 56% of the total MAPP population or 881 individuals).

It appears that very few applicants are reporting MRE or IRWE expenses. Only 5% of the applicants reported IRWE expenses. The average IRWE expense was $164; the minimum was $3 and the maximum was $1,409. The following chart categorizes the 78 reported expenses by category.



[10] MRE and IRWE expenses are listed in attachment L of section VIII Appendix.

Just over 6% of the applicants had identified MRE expenses on their application. The average MRE expense was $99[11]. The minimum MRE was $.41for eyeglasses[12] and the highest was $18,075 for outstanding medical bills. Virtually all of the costs were medical in nature. Medicare premiums were listed 10 times and other health insurance premiums were listed eight times. The health insurance premium costs ranged from $80.60 to $208.70 per month. These costs are particularly noteworthy because the Medicaid benefit package is typically more generous than or duplicative of private coverage. One would not expect an individual on MAPP to be paying for additional health care coverage.

Third-Party Liability

From Medicaid claims data, it appears that a significant majority of the MAPP enrollees are also eligible for Medicare. Approximately 82% of MAPP enrollees were eligible for Medicare Part A, Medicare Part B or both. In addition to Medicare, some MAPP enrollees are receiving coverage of their health care services through a third-party payer. In June 2001, 8.8% of the MAPP participants had a third-party payer identified on their Medicaid eligibility record. There were also five individuals who had a HIRSP claim during the time period of their MAPP eligibility. Again it is not clear why an individual would continue to pay premiums for HIRSP coverage once they became eligible for Medicaid through MAPP.

[11] Two costs under $1 and one cost of $18,075 were considered outliers and were not included in this calculation.

[12] Some of these very low MRE costs are questionable. One time costs may be prorated across the year, but converting the $.41 monthly cost to an annual cost yields a total cost of $4.92 for a pair of glasses.

V. Fiscal Evaluation

The purpose of the fiscal evaluation is to monitor the effects of MAPP on State and Federal Medicaid funding and to measure its impact on locally funded long-term care services. Evaluation staff have faced a number of challenges in attempting to measure the fiscal impact of the MAPP program. Specifically, evaluation staff have not been able to identify the costs associated with administering the MAPP program nor have they been able to quantify the impact of MAPP on locally funded long-term care services.

While the MAPP program has its own set of eligibility requirements and program policies, in terms of its administration it is functionally a sub-component of the larger Medicaid program. As such, its administrative costs (operational staff, local enrollment staff, eligibility and claims processing) are not discernable from other Medicaid administrative costs. In other words, MAPP administrative costs are not accounted for separately by the state. Consequently, our analysis of the effect of MAPP on State and Medicaid funding will be limited to direct service costs associated with the program[13].

Evaluation staff have also made efforts to collect quantifiable information from counties regarding the impact of MAPP on their local long-term care budgets. It had been expected that MAPP would provide some financial relief to counties by creating opportunities to shift county funded long-term care costs to the Medicaid program by making more working disabled individuals eligible for Medicaid. Measuring this goal poses a challenge because counties generally do not keep comprehensive records of long-term care cost at an individual level so that MAPP participants who had previously been receiving county funded services can be readily identified. Counties subcontract with other community providers for the provision of long-term care services, which also makes tracking individual costs very difficult. In year two of the evaluation, alternative methods for obtaining data to measure this goal will be explored, such as data from the Health and Human Service Reporting (HSRS) system.

The fact that the majority of MAPP enrollees were participating in Medicaid just prior to their MAPP enrollment also poses a challenge for measuring the impact of MAPP on the overall Medicaid budget. Evaluation staff will be working with CDSD staff over the next year to develop a model for identifying the fiscal impact of MAPP on the Medicaid budget. This model will need to consider a number of factors, including: (a) the number of MAPP participants who would have been enrolled in Medicaid in the absence of MAPP; (b) changes in Medicaid costs that can be attributed to participation in MAPP (i.e. impact of work on health status); and (c) the impact of MAPP premiums on program costs.

[13] The cost of administering the HEC component of the MAPP program can be quantified because these services are provided by ERI under a separate contract with CDSD. For state fiscal year 2001-02, $105,000 was budged for the administration of HEC. This budget covers all aspects of administering the HEC program, including supervisory and administrative support provided by ERI, subcontracts with regional HEC screeners, training costs and all travel expenses associated with the program.

At this time, it is possible to provide summary data on the overall health care costs and utilization of MAPP individuals. Medicaid claims data were analyzed to provide information on the types and costs of services utilized by MAPP participants. MAPP costs and utilization are compared between participants who did and did not have Medicaid coverage prior to enrolling in MAPP. Finally, health care cost and utilization data are presented for a comparison group of disabled Medicaid recipients.

Total benefit expenditures on behalf of MAPP participants were over $5.3 million in state fiscal year (SFY) 2000-01. The state share of these costs was approximately $1.96 million. The remaining costs were supported with $191,555 in premium revenue, as well as federal Medicaid matching funds totaling $3.12 million.

Claims for MAPP users were analyzed by quarter over the period January 2000 through June 2001 to determine the overall cost of providing services to all MAPP enrollees. As would be expected, the number of claims increased dramatically over this period as the number of MAPP enrollees increased. In the first quarter of the program[14], 85 enrollees were eligible for services through the MAPP program. During the sixth quarter (April 2001 through June 2001), the number of eligibles had grown to 1,184.[15] Between first and sixth quarter, the number of claims submitted on behalf of MAPP participants also increased considerably from 621 to 20,475 and the percentage of participants receiving services increased from 77% to 95%.

The cost of providing benefits to MAPP enrollees has increased proportionately to the number of enrollees and claims submitted since the program's inception. First quarter users of MAPP services utilized a total of $40,650 in health care services. By the sixth quarter, MAPP participants utilized a total of $1,722,498 in health care services during the quarter. In addition to measuring changes in total cost, per user[16] service utilization and costs were also examined to determine if participants are using more or more expensive services over time.

MAPP enrollees appear to be using more and more expensive services. The average cost per claim increased from $65 in the first quarter to $84 in the sixth quarter. The number of claims per user has also increased steadily since January 2000. An average of 9.5 claims per user was submitted during the first quarter, a figure that nearly doubled to 18.3 by the sixth quarter. The increased number of claims and more expensive claims both contributed to the total cost per user increasing dramatically during the analysis period.

---

[14] While individuals began enrolling in MAPP in March, Medicaid policies allows for up to three months of retroactive eligibility. Under these policies, some individuals were determined to be Medicaid eligible under MAPP beginning in January 2000. Therefore, for the purposes of this analysis, "first quarter" refers to the period January 2000 through March 2000.

[15] Please note that all data in this section reflects information at the time of data extraction (July 2001) and should be considered preliminary. Due to lags in claims submission and processing, as well as the ability to backdate eligibility determinations, eligibility and claims data are not considered final until a number of months after the month in question. Therefore, claims and eligibility data for April – June 2001 are incomplete.

[16] Users are defined as unique MAPP enrollees who submitted a claim during the specified time period.

The average per user cost increased from $625 in the first quarter to $1,539 in the sixth quarter.

The following table provides additional information on MAPP claims and expenditures.

Claims & Amounts Paid
MAPP Eligibles & Users
for Service Dates of January 2000 through June 2001

	Quarter 1 January '00 - March '00	Quarter 2 April '00 - June '00	Quarter 3 July '00 - September '00	Quarter 4 October '00 - December '00	Quarter 5 January '01 - March '01	Quarter 6[3] April '01 - June '01	Total January '00 - June '01	Calendar Year January '00 - December '00	State Fiscal Year July '00 - June '01
Eligibles[1]	85	292	625	965	1,239	1,184	1,331	1,007	1,322
Users[2]	65	238	535	861	1,120	1,119	1,287	919	1,279
Claims	621	2,662	8,553	13,678	20,412	20,475	66,401	25,514	63,118
Amount Paid	$40,650	$171,021	$683,393	$1,071,552	$1,799,410	$1,722,498	$5,488,524	$1,966,616	$5,276,853
Amount per Eligible	$478	$586	$1,093	$1,110	$1,452	$1,455	$4,124	$1,953	$3,992
Amount per User	$625	$719	$1,277	$1,245	$1,607	$1,539	$4,265	$2,140	$4,126
Claims per User	9.55	11.18	15.99	15.89	18.23	18.30	51.59	27.76	49.35
Amount per Claim	$65	$64	$80	$78	$88	$84	$83	$77	$84

[1] All MAPP eligibles during the specified time period, regardless of claim status.

[2] MAPP individuals who used a health care service during the quarter (i.e., had a claim submitted for a date during the quarter).

[3] Quarter 6 data does not include individuals with MAPP eligibility begin dates prior to April 1, 2001. It takes approximately three months for the MAPP enrollment data to become stable due to backdating of eligibility determinations. Claims data are also subject to submissions lags. Therefore, the totals represented in Quarter 6 reflect lower numbers than actually occurred during that period. It is expected that the data lag will not effect the relationships between the totals for Quarter 6. All trends analyzed using data from Quarter 6 should exhibit similar characteristics to previous quarters where complete data was used. Future analyses of Quarter 6 data will include updated figures.

To better understand the health care expenditures made on behalf of MAPP participants, claims were also reviewed to identify the types of services being used. The Medicaid Management Information System (MMIS) is programmed to categorize individual health care services into pre-defined categories of service (COS). The following table provides detailed information on the types of services used by MAPP participants in SFY 2000-01.

Amounts Paid for MAPP User Claims
by Quarter and Category of Service (COS)
for Service Dates of July 2000 through June 2001

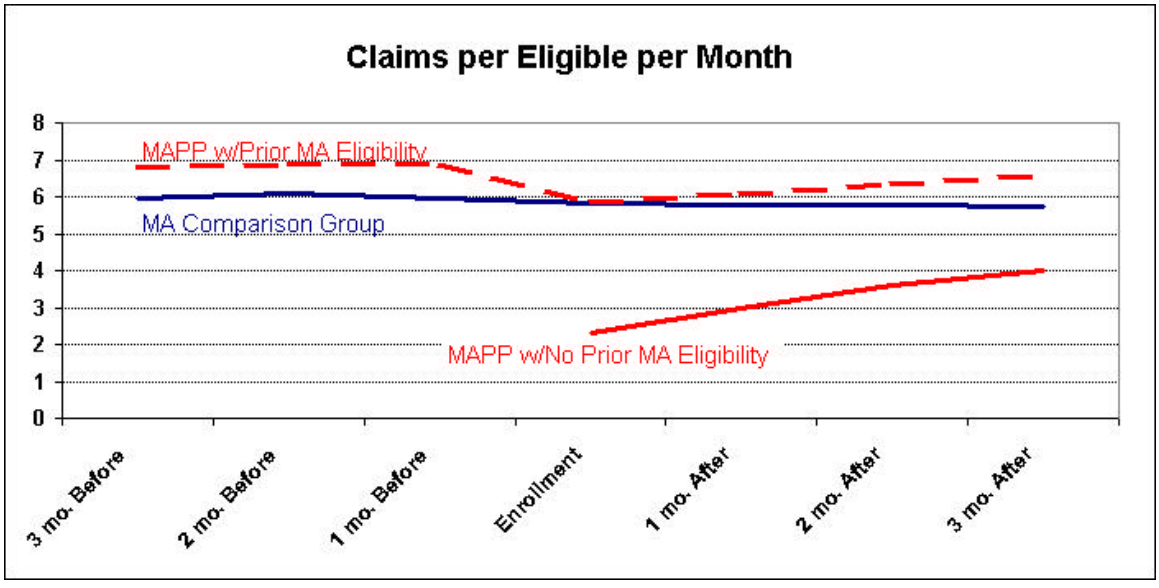
	Quarter 3 July '00 - September '00			Quarter 4 October '00 - December '00			Quarter 5 January '01 - March '01			Quarter 6 ^ April '01 - June '01			Total July '00 - June '01		
Category of Service (COS)	*Users*[*]	*Amt. Paid*	*Amt./ User*	*Users*	*Amt. Paid*	*Amt./ User*	*Users*	*Amt. Paid*	*Amt./ User*	*Users*	*Amt. Paid*	*Amt./ User*	*Users*	*Amt. Paid*	*Amt./ User*
Inpatient Hospital Services (1)	13	$64,284	$4,945	9	$44,231	$4,916	21	$178,803	$8,514	13	$44,603	$3,431	46	$331,921	$7,216
ICF Services for Mentally Retarded (5)	-	-	-	-	-	-	-	-	-	2	$4,723	$2,361	2	$4,723	$2,361
ICF Services All Other (6)	-	-	-	1	$5,154	$5,154	1	$6,500	$6,500	-	-	-	1	$11,654	$11,654
SNF Services (7)	2	$3,536	$1,768	1	$3,031	$3,031	1	$369	$369	2	$1,751	$876	4	$8,686	$2,171
Physicians Services (8)	49	$8,312	$170	93	$12,265	$132	121	$9,058	$75	79	$10,050	$127	232	$39,684	$171
Dental Services (9)	68	$6,586	$97	132	$11,797	$89	211	$19,526	$93	209	$22,937	$111	436	$60,846	$140
Other Practitioners Services (10)	51	$2,022	$40	82	$3,096	$38	133	$5,644	$42	116	$4,683	$40	268	$15,444	$58
Outpatient Hospital Services (11)	80	$17,422	$218	96	$25,393	$266	132	$38,037	$288	114	$31,555	$277	260	$112,407	$432
Clinic Services (12)	172	$19,566	$114	240	$24,501	$102	338	$52,268	$155	273	$36,829	$135	560	$133,163	$238
Home Health Services (13)	47	$44,591	$949	80	$83,385	$1,042	119	$113,479	$954	119	$123,300	$1,036	186	$364,754	$1,961
Family Planning Services (14)	25	$1,321	$53	45	$2,084	$46	84	$3,294	$39	161	$4,610	$29	221	$11,310	$51
Lab and X-Ray Services (15)	80	$4,969	$62	129	$7,490	$58	101	$14,112	$140	146	$11,269	$77	337	$37,959	$112
Prescribed Drugs (16)	419	$322,468	$770	739	$556,468	$753	974	$816,764	$839	997	$932,631	$935	1156	$2,628,332	$2,274
EPSDT (17)	-	-	-	7	$101	$14	2	$10	$5	2	$41	$20	11	$152	$14
Rural Health Clinic Services (18)	1	$0	$0	6	$257	$43	7	$736	$105	7	$686	$85	15	$1,586	$106
Other Care (19)	217	$97,913	$451	354	$150,000	$424	488	$243,534	$520	444	$221,734	$499	688	$713,181	$1,037
Capitation Payments (HMO and Buy-In) (20)	9	$35,851	$3,983	18	$75,225	$4,179	27	$142,704	$5,285	26	$147,629	$5,678	29	$401,410	$13,842
Institutional Cross-Overs (96)	25	$17,509	$700	24	$17,428	$726	55	$37,972	$690	54	$39,441	$730	135	$112,350	$832
Professional Cross-Overs (97)	207	$31,228	$151	485	$42,365	$87	684	$109,762	$160	705	$79,584	$113	929	$262,940	$283
CCO (98)	1	$5,816	$5,816	2	$7,281	$3,641	2	$6,838	$3,419	1	$4,515	$4,515	2	$24,451	$12,225
Total	535	$683,393	$1,277	861	$1,071,552	$1,245	1,120	$1,799,410	$1,607	1,119	$1,722,498	$1,539	1,279	$5,276,853	$4,126

Note: No claims were submitted for the following categories of service (COSs) during the periods specified: Mental Hospital Services for the Aged (2), SNF/ICF Services for the Aged (3) and Inpt. Psych. Facil. Serv. for Ind. Age 21 & Under.
[*] Individuals with MAPP eligibility on their first service date with a corresponding claim(s).
^ All eligibles/users with eligibility begin dates after April 1, 2001 were excluded from the analysis. (See footnote 3 in the table above)

The majority of MAPP-related health care expenditures are for prescription drugs. More MAPP participants were using the prescription drug benefit than any other service. Overall, 1,156 unique users (87%) submitted claims for prescription drug benefits during the state fiscal year. Total expenditures for prescription drug benefits paid during the fiscal year were over $2.6 million and accounted for more than half of all claims expenditures. During the same period, no claims were submitted for mental health services for the aged, skilled nursing facility (SNF)/intermediate care facility (ICF) for the aged and inpatient psychiatric facility services for individuals age 21 and under.

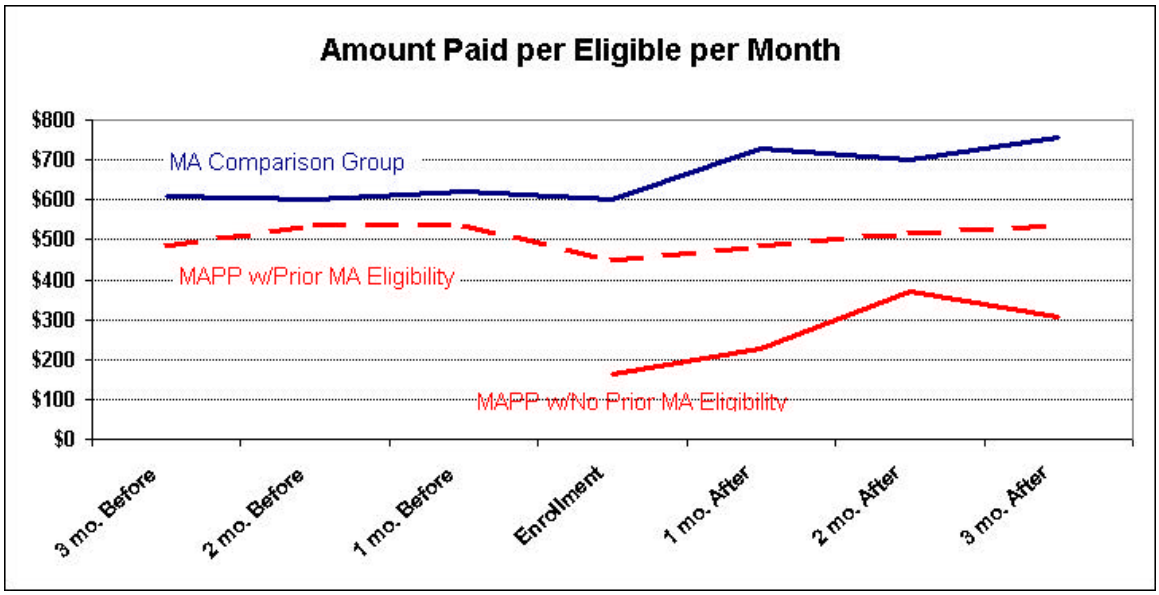
Based upon the claims and expenditure data discussed above, additional questions arose regarding benefit utilization and expenditures for MAPP enrollees as they compare to benefit utilization and expenditures for other Medicaid (MA) populations. To better understand the differences in utilization and expenditures for MAPP and non-MAPP MA groups, an analysis was conducted utilizing a matched sample comparison group of non-MAPP MA recipients. In addition, MAPP enrollees have been broken out by prior MA eligibility experience. For the purpose of this comparison, individuals are counted as "previously enrolled" in MA if they had disability-related medical status codes for SSI, SSI-Related, Medicare, Waiver, or Nursing Home, within the time period between July 1, 1999 and their initial enrollment in MAPP, through March 31, 2001. By this definition, 767 out of 1331 (58%) MAPP enrollees were MA eligible immediately prior to their MAPP participation. The groups evaluated in this comparison are:

- MAPP enrollees with no prior MA eligibility (solid red line)
- MAPP enrollees with prior MA eligibility, as defined above (dashed red line)
- Non-MAPP MA enrollee matched sample comparison group (solid blue line)



MAPP participants previously enrolled in MA are very similar to the matched control group of non-MAPP MA recipients in terms of utilization (measured by the number of claims submitted per individual) and expenditure patterns before and during MAPP enrollment. The MAPP individuals have slightly higher utilization rates, and slightly

lower expenditure rates than the non-MAPP group. Despite a slight dip in utilization and expenditures for MAPP individuals during their month of enrollment, this pattern appears to hold. This relationship is evident three months prior to MAPP enrollment, as well as three months after MAPP enrollment.



Individuals who enroll in MAPP without prior MA eligibility have approximately two to four fewer claims per month, and about $200 lower expenditures per eligible per month compared with previously MA-eligible MAPP enrollees, and about $400 lower expenditures per eligible per month compared with non-MAPP MA recipients, on average.

MAPP participants appear to be utilizing more and more expensive services over time. It also appears that MAPP enrollees without prior MA eligibility are increasing their utilization at a greater rate (steeper line) than their prior MA eligible counterparts. This heavy utilization in the first three months of the program may reflect the fact that these individuals have not had access to health care coverage and are "catching up" on their health care needs in the early months of the program. However, any conclusions drawn from this analysis should be considered carefully given the preliminary nature of the data.

Year two data should provide a better barometer of the utilization and expenditure trends of MAPP enrollees. Further analysis in year two of the program should establish a "base" level of claims, including types of claims, to be expected from MAPP enrollees. Future analyses will focus on comparing expenditures by category of service for non-MAPP MA eligibles and MAPP eligibles to determine where the populations are similar and in what benefit areas they may diverge.

VI. Process Evaluation

The purpose of the Process Evaluation is to determine whether MAPP was implemented equitably across the State and to evaluate whether the program, as currently designed, is efficient and effective.

Two surveys will be administered in year two of the evaluation to further study process issues. The MAPP recipient survey will provide information on the MAPP enrollment process and the administration of the program from the recipient's point of view. This survey began in the first year of the evaluation. A survey of ES Workers will also be administered to provide additional insight into the administration of the program from the counties' point of view.

In year one, evaluation staff have observed a number of process issues related to the state and county administration of MAPP. Issues related to the submission of application forms and the completeness of the forms included in the process evaluation. This section identifies process issues related to both the calculation and the structure of MAPP premiums. Anecdotal information on process issues from the local perspective is also reported. This information was collected through a number of venues, including county interviews, discussion with Pathways to Independent Benefit Specialists and comments from county staff at a statewide long-term care meeting. Finally, modifications to the HEC program undertaken by the state to make the program more effective in year two of MAPP are summarized.

State and County Administration Issues

The MAPP program was implemented without making changes to the Client Assistance Re-Employment and Economic System (CARES), which is the automated system used by counties to determine eligibility for Medicaid and other public assistance programs. MAPP eligibility was not automated on CARES when the program was first implemented because modifications were in process for the Family Care program. It is expected at the time of this writing that MAPP will be automated on CARES in the fall of 2001. In the meantime, MAPP eligibility is determined through the manual process of completing a MAPP application.

The MAPP application is comprised of the: (a) Eligibility Worksheet, (b) Schedule A-for Calculating Total Family Income, (c) Premium Calculation Worksheet, (d) Medical Related Expense (MRE)Worksheet and (e) Independence Related Work Expense (IRWE) Worksheet. In addition to being the basis for determining MAPP eligibility, the application provides information that is important for the MAPP evaluation, including:

- Onset date for meeting disability determination (as determined by DDB)
- Satisfaction of the work requirement
- HEC enrollment
- Income
- Countable assets
- Family size

- Premium amount, if any
- Type and amount of MRE and IRWE expenses

A sample of the MAPP application worksheets are included as attachment L in Section VIII Appendix.

The application also includes a number of optional questions relating to utilization of other publicly supported insurance programs, such as HIV/AIDS insurance and HIRSP, Medicaid retroactive coverage and sources of payment for the applicant's health services or equipment for the last year.

Counties are required to forward a copy of all application forms to CDSD. Under the MAPP evaluation contract, the evaluation staff developed a database for capturing data from the paper MAPP application in an electronic format so that it could be utilized for the evaluation of the program. Information from the paper forms is keyed into an Access database, creating a MAPP application database.

In addition to providing information for the evaluation, the applications allow an assessment of the ES workers' accuracy in completing the application forms. For example, the applications allow for an evaluation of whether the eligibility determination was completed properly and whether the worker calculated the correct premium for the applicant.

Counties have not been consistently submitting the MAPP applications to the state and many of the applications submitted contain errors, while others are incomplete. To date, some portion of an application form has been received for approximately 56% of the individuals enrolled in MAPP since the program's inception. It should be noted that just over 7% of the applications sent to the CDSD represent individuals who did not subsequently enroll in MAPP.[17] Errors found on the applications include:

- Missing forms
- Missing date of birth
- Missing filing date
- Incorrect or missing Social Security number
- Incorrect income for premium calculations
- Inconsistent information between worksheets

Of the 1,090 applications received through July 16, 2001, almost 15% were missing one of the required worksheets. On just over 10% of the applications, the county worker had used the wrong income amount from Schedule A for determining whether the applicant would be required to pay a premium under the program. (Additional information on premium calculation errors is provided under "Premium Calculations"). Approximately 10% are missing the Medicaid filing date.

[17] Individuals who did not subsequently enroll in MAPP is defined as individuals who do not have a MAPP eligibility segment in the Medicaid Management Information System (MMIS).

Submission of MAPP Eligibility Forms

Until MAPP is automated on CARES, counties are directed to submit MAPP applications to the CDSD. A total of 76 county agencies have enrolled individuals in MAPP. Of these, 12 agencies have submitted zero applications. To date, 11 county agencies have submitted applications for at least 90% of their participants. Attachment M in section VII Appendix, provides a county by county summary of MAPP enrollment and application submission.

Counties have also submitted at least three different versions of the application, two of which are missing an essential data element for the eligibility determination – HEC participation. The Medical Assistance Handbook ("Handbook") walks county ES workers through the Medicaid eligibility process for all Medicaid subprograms. This Handbook is updated periodically through memorandum issued by the Department of Workforce Development. The memoranda highlight changes to the Handbook and provide replacement pages for the sections of the Handbook that are being updated.

On July 1, 2000 ($3^{1/2}$ months after the program was first implemented), county ES workers received an update to the Handbook, which included new MAPP application forms. However, the version of the eligibility worksheet provided did not include the question regarding HEC participation. Shortly thereafter (7/24/00) ES supervisors and ES lead workers received the corrected worksheets with the HEC program reference. Two months later, in an October 2000 update, the new updated worksheets were incorporated in the Handbook, although these new forms were not highlighted as one of the changes included in the update.

The lack of compliance with the application requirement impacts the ability of the CDSD and Wisconsin Medicaid to effectively administer the program. For example, without the application forms, situations in which an individual has been incorrectly certified as MAPP eligible or has had their premium calculated incorrectly can not be identified. Evaluation staff also have a direct interest in seeing the counties comply with the application submission requirement and with having all counties utilizing the same and most up-to-date version of the application in order to conduct trend analyses.

Consequently, the evaluators in conjunction with CDSD and DHFS, Bureau of Health Care Eligibility (BHCE) have been pursuing efforts over the last year to obtain the missing applications and to ensure that the counties are all using the correct version of the application. The following is a summary of the discussions over the last year at CDSD, BHCE and evaluation staff monthly meetings regarding the various application issues and the progress of efforts to obtain copies of the applications from the counties.

June 2000. CDSD informed the evaluation staff that the automation of MAPP on CARES was delayed until at least March 2001. At that time 53 individuals were enrolled in MAPP, but the CDSD had not yet received copies of any MAPP applications. CDSD indicated it would be sending counties a second reminder to submit the applications in the next few weeks.

July 2000. CDSD reported that it was exploring options for establishing a system for counties to submit the MAPP applications, such as providing postage paid envelopes.

August 2000. After receiving applications for 19 individuals, CDSD reported that it was aware of errors in the eligibility determinations. Information regarding these errors was forwarded to the Bureau of Health Care Eligibility (BHCE) by the Center. There were initial and follow-up contacts with the caseworkers that had submitted applications with errors.

November 2000. Evaluation staff inquired about plans to modify the system for collecting applications as the compliance rate was still very low. CDSD staff expressed surprise at the low rate and said they would move exploration of possible resolutions up on their priority list.

Also at this meeting, the evaluation staff presented a sample of MAPP applications, which illustrated a number of inconsistencies. ES workers were using three different versions of the application forms. The most significant differences between the forms were that 2 of the 3 versions did not include a question regarding HEC enrollment and did not allow for assignment of unearned income to both an applicant and his/her spouse.

December 2000. The evaluation staff inquired on the status of a plan to increase county compliance for submission of applications. CDSD reported that a plan had not been developed, but that they would schedule an internal meeting to discuss alternatives. The evaluation staff created a "Missing Applications Report" that identified by county and caseworker ID#, the MAPP eligibles for whom an application had been submitted to the state and those for whom the application was missing.

January 2001. CDSD reported working with BHCE to develop a plan for increasing county compliance with form submission. BHCE staff later joined the meeting and further discussions resulted in the following plan. The evaluation staff would update the missing applications report and modify the report to include both SSN and the CARES ID for recipients. BHCE would use the report to request the missing applications from the counties and would also send a reminder going forward that copies of the applications must be sent to CDSD.

February 2001. BHCE reported that it would be sending out an electronic notice to the counties that week. The evaluation staff raised the issue of multiple versions of the forms still being in the field. Shortly after the meeting, BHCE indicated it would obtain the most current/final versions of the worksheets and would develop an operations (OPS) memo and get the latest versions of the worksheets in the field.

March 2001. An electronic notice was sent to counties reminding them to send copies of all MAPP applications and changes to CDSD. That communication did not include a notice regarding the missing applications or a set of the current version of the application with directions to replace all prior (i.e. incorrect) versions of the application.

April 2001. Evaluation staff, CDSD and BHCE met twice in April. At the initial meeting, BHCE agreed to send out a letter and missing application report to each county, if CDSD would draft the letter. The letter was drafted and sent to BHCE on April 24th. Upon receipt of the draft, BHCE indicated that the letter would be sent out by the end of the following week.

May 2001. No new information on the missing application mailing or the effort to remedy the situation of "old" forms being in the field was reported at the May meeting.

June 2001. On June 25, BHCE indicated that it was ready to mail the letters and missing application reports.

July 2001. On July 24th meeting, BHCE indicated that the letter was ready to be sent. At the time of this writing (August 1, 2001) the letter has not been sent.

Premium Calculations

The MAPP application database developed by the evaluation staff was built with the capacity to evaluate the ES workers' ability to complete the MAPP application accurately. For example, the database calculates a MAPP premium for each applicant using the income information reported on the worksheets. The calculated premium can then be compared to the premium reported by the ES workers and to premium payment records. Once the MAPP applications were being entered into the database, it became apparent there was considerable confusion among the ES workers regarding premium levels, which raised questions regarding the program being implemented equitably across the state.

Initial information provided to ES staff and consumers regarding premium amounts, including the premium schedule published in the Consumer Guide, indicated that individuals whose premium income[18] was between $0 and $10.00 would not be subject to a premium. Premium income between $10.01 and $25.00 would qualify an individual for a $10.00 premium. Early reviews of applications indicated that some ES workers were "waiving" the $10.00 premium.

In October 2000 (seven months following implementation) an update to the Handbook made the $10 premium waiver official policy. The memo included a revised premium schedule and identified the following change "The premium table was adjusted. There are no premiums under $25". However, the memo did not provide instructions on how to handle cases that were currently paying a $10 premium. In December of 2000, an analysis identified 29 individuals paying a $10 premium.

Confusion about the $10 premium persisted for a number of months after the new policy was issued. On April 5, 2001, at a DHFS statewide long term care and aging conference, discussion between county and state Medicaid eligibility staff indicated that there was

[18] "Premium Income" is the sum of monthly adjusted unearned and adjusted earned income. Please see detailed explanation in section III Program Overview.

still misunderstanding between state and county staff as to whether or not a $10 premium should be waived.

In mid-May, individuals who were paying a $10 premium were sent refund checks for all $10 premiums paid in error and a letter explaining that DHCF had determined that premiums of less than $25 would be waived for all past and future months. The last letter was sent July 5, 2001 and it appears that ES Workers are no longer certifying individuals for a $10 premium.

Analysis of premium worksheets indicated that some county workers are also calculating premium amounts incorrectly. In the majority of the cases, the worker is testing the applicant for premium liability using his/her adjusted family income, rather than their individual gross monthly income. Individuals with gross monthly income in excess of 150% of the federal poverty level are supposed to pay a premium. As stated earlier, approximately 10% of the returned applications exhibit this error. As a result of this error, there is a chance that an individual will be incorrectly categorized as eligible for MAPP with no premium.

We conducted a review of 33 applications for individuals who met the following criteria:

- An application was on file with the state and the individual had actually enrolled in MAPP;
- The application database calculated a premium for the individual, but there was no record of the individual ever paying a MAPP premium; and
- The calculated premium was in excess of $100.

Our review found that in 14 of the 33 applications, the error had been made in the last three months (April 2001– June 2001) and that the errors had been made by 27 different certifying agencies. The following table identifies the monthly premium amounts that should have been paid had the applications been processed correctly.

Premium Amount	Number of Individuals
$100	2
$125	3
$150	4
$175	4
$200	4
$225	2
$250	3
$275	4
$300	1
$325	1
$350	2
$375	1
$400	2

The total amount of missed premiums from these 33 individuals is $7,475 per month or $89,700 per year. From April through June, total premium collections averaged $22,900 per month. Consequently, if premium had been collected from these individuals, total premium revenues should have been 33% higher in those months. This review provides a conservative estimate of the missed revenues that are resulting from premium calculation errors because it was limited to premiums over $100 and only 56% of the applications were available for review.

Premium Structure

One of the state program goals was to implement MAPP in an equitable manner across the state. In addition to concerns about lost program revenues, the errors described in the previous section suggest that the program has not met this goal. The fact that an applicant for MAPP may or may not be required to pay a premium depending on which worker processes their application detracts for the goal of equitable implementation. Another issue of equitability that has been raised related to MAPP premiums is the structure of the premium calculation formula.

The MAPP premium structure has been criticized as inequitable by some advocates and DHFS staff. MAPP is a means tested program. One rationale for means tested programs is that as one's income increases so does their ability to cover the costs of certain needs, such as health care. The eligibility criteria and premium schedule for MAPP are based on income as a percentage of the federal poverty level (FPL). By setting the premium threshold at 150% of the FPL, the policy suggests that individuals with income above this level have resources available to support a percentage of their health care costs. The level of expected support increases as one's "income" increases. It is the definition of "income" for the purposes of the identifying premium amounts that makes the premium calculation inequitable according to some.

The MAPP definition of income for premiums treats earned and unearned income differently. One's premium liability does not increase proportionately to one's increase in total income. Rather, it increases disproportionately with one's increase in unearned income as a result of the formula. MAPP applicants are expected to contribute 3% of their adjusted earned income toward their premium, while they are expected to contribute 100% of their adjusted unearned income. The effect of this disparity is that individuals with the same total income, but with different ratios of earned and unearned income could be paying significantly different premiums. For example, there was a MAPP applicant who applied in March 2001 with a large amount of unearned income relative to her earned income ($1,040 unearned versus $5 earned). Her total gross monthly income was $1 over the 150% FPL threshold so she would be required to pay a MAPP premium. Her premium would have been $400. A premium of this amount represents 38% of her gross monthly income. If the amounts of her earned and unearned income had been reversed, her premium would have been waived because it was less than $25.

While some have criticized the premium structure, others have argued that the premium formula was structured to provide strong work incentives. In a memo addressed to Department of Administration staff dated October 21, 1998, DHFS recognizes the differential treatment of earned and unearned income and identifies it as a policy that builds work incentives into the premium structure. The memo goes on to say that another advantage of the premium structure is that it targets people who can and will work at a substantial level. Applicants with minimal employment and high unearned income would be discouraged from participating in the program. Earned and unearned income are directly linked for many of the MAPP applicants who receive federal Social Security Disability Income (SSDI) payments. The amount of one's SSDI payment (counted as unearned income) decreases as one's earned income increases.

Earned and unearned income amounts were reviewed for MAPP enrollees who have an application on file with CDSD to determine if MAPP is reaching its intended audience and to measure the success of the premium structure as it relates to work incentives. The following table provides median earned and unearned income amounts for individuals in four categories: (1) MAPP enrollees without premium liability (income is below 150% of the FPL); (2) MAPP enrollees who have had their required premium waived (premium would be below $25); (3) MAPP enrollees who pay a $25 premium; and (4) individuals who pay a premium greater than $25.

	Number of Enrollees[19]	Median Earned Monthly Income[20]	Median Unearned Monthly Income[21]
No Premium Liability	748	$159	$662
Premium Waived	312	$562	$578
$25 Premium	88	$960	$624
Over $25 Premium	250	$494	$803
Total	**1,398**	**$342**	**$658**

As this table illustrates, the premium structure does benefit individuals who have low amounts of unearned income. Individuals with a waived premium or a $25 premium, in general, have lower unearned income than those paying a premium over $25. However, one's earned income appears to have a weaker relationship with one's premium liability. The median earned income for over $25 premium payers is slightly less than the median earned income of the premium waived cohort, but the mean earned income for this group is slightly higher ($590 versus $544). Therefore, individuals with very similar amounts of earned income are required to pay substantially different amounts to participate in MAPP. If substantial employment were based on earnings, the program does not appear to be targeting individuals who are engaged in substantial employment. The majority of enrollees earn less than $342 a month and 67% earn less than $500 per month. It is also interesting to note that the median unearned income amount for the no premium liability group is only $38 higher than the $25 premium group, while the median earned income is $801 less. This suggests that increases in earned income do not necessarily result in proportional reductions in unearned income for the MAPP population.

Local Perspectives

A survey to capture information from ES workers on the administration of the MAPP program is drafted and approved**.** Results from this survey will be available in year two of the evaluation.

In the interim, anecdotal information from local staff has been gathered from a number of sources, including: comments of county staff attending the Long Term Care and Aging Conference on April 5, 2001, a meeting of Pathways to Independence (PTI) Benefit Specialists on May 24, 2001 and selected telephone interviews with county staff conducted from June 20, 2001 through June 28, 2001. A special session on MAPP was held at both the long term care and the PTI Benefit Specialist meetings. The long term

[19] This analysis has been added to the report as a revision. Consequently, more MAPP applications were available for review than were available at the initial writing of the report.

[20] Monthly earned income represents the applicant's gross earned income as reported at the time of application.

[21] Monthly unearned income represents the applicant's gross unearned income as reported at the time of application. Unearned income typically includes Social Security benefits, disability benefits and pension income.

[21]

care session on MAPP was moderated by BHCE. The Pathways Benefit Specialist session was moderated by Anne Reither from CDSD and Amie Goldman from the evaluation staff. Telephone interviews were conducted by the evaluators with a representative from each of the following counties: Milwaukee, La Crosse, Marathon, Dane and Sheboygan. These five counties are among the top ten for having the highest percentage of MAPP enrollment.

A more detailed summary of the telephone interviews is included in the section VIII Appendix as Attachments M and N.

Telephone Survey Responses

When asked how the program is working, all the local staff agreed that the program was helping people in their community and most respondents felt the program was working well for the people it was able to reach. However, respondents also agreed that there was a need for additional outreach to identify and enroll more people who may be eligible for the program. The lack of outreach to both potential enrollees and possible referral sources (e.g. social services workers) and publicity for MAPP were identified as program weaknesses. The counties themselves did not report that they had been engaging in any concerted outreach efforts. Although, there was evidence of some limited outreach activities, such as meeting with a community agency or health care facility.

Respondents were also concerned about the administrative burden of the application process. It was viewed as complex and cumbersome. The lack of additional resources to support the administration of MAPP was also identified as a shortcoming.

The counties were not able to say for certain that MAPP had helped them shift funding for long-term care services from the county to state and federal budgets, although, a few respondents indicated that they thought this was the case. A couple of counties noted that MAPP had increased their waiver enrollment and four out of the five indicated that MAPP had helped non-Medicaid recipients obtain health care coverage.

PTI Benefit Specialist Comments

The PTI Benefit Specialist session on MAPP included representatives of agencies located in the following counties: Dane, Sauk, La Crosse, Milwaukee, Winnebago, Jefferson/Waukesha, Dunn, Rock, Eau Claire and Brown. Both Dane and Milwaukee were represented by more than one agency. The areas served by each PTI Benefit Specialist are often much larger than the county in which their primary office is located. Approximately 25 people were in attendance. About 75% of the attendees had assisted a PTI participant to enroll in MAPP; nearly everyone had discussed MAPP with a consumer who was considering enrollment.

When MAPP was first developed, it was expected that a significant number of PTI clients would enroll in MAPP. PTI is a research and demonstration project, which seeks to remove barriers to employment for people with severe disabilities and to provide ready access to the comprehensive help they need in order to work. PTI does not have a health care coverage component. It was expected by program developers, the Legislature and

community stakeholders that PTI participants who did not have access to employer-based coverage and whose income disqualified them from Medicaid eligibility would receive health care coverage through MAPP. In this way, MAPP could provide additional support of PTI participants. Of the 492 individuals who have enrolled in PTI, 59 or 12% have also enrolled in MAPP. PTI participants represent less than 4% of the MAPP population.

Several attendees indicated that they had also expected more PTI participants to enroll in MAPP. The reasons offered for the low overlap between PTI and MAPP were:

- Many PTI participants are on SSI and are already categorically eligible for Medicaid.
- Those who are SSDI can't afford the MAPP premiums, which are too high because of the treatment of unearned income in the premium calculation.
- The pressure to sustain work is too stressful. MAPP requires individuals to work consistently over time and is perceived as threatening for people who have sporadic work histories and/or anticipate disability-related work absences in the future. Some PTI benefit specialists reported screening out individuals with sporadic work histories.
- Some PTI participants are still dealing with barriers and aren't yet ready to work.

If PTI Benefit Specialists had counseled individuals to participate in MAPP, they were asked to characterize their experience with the application process. They were also asked to comment on the implementation and ongoing administration of MAPP at the county level. Finally they were asked to comment on the premium structure and the HEC component of the program.

A primary concern expressed by the specialists was the lack of client access to ES Workers who understood the MAPP program. Examples were given of MAPP applicants being told that MAPP was a program for pregnant women or that MAPP was not available to single, childless individuals and in some cases applicants were told that the MAPP program doesn't exist. Some of this may have been due to the fact that training for MAPP occurred after the implementation date. Counties were instructed not to process applications until after they had been trained. In the interim, they were supposed to start the MAPP eligibility process by completing an interactive interview for Medicaid in CARES and then wait to certify the applicant for MAPP after their training. However, the PTI Benefit Specialist's comments suggest that some ES workers were not provided with even a basic understanding of the MAPP program prior or subsequent to its implementation. One county stated that "everyone else" knew about MAPP before the ES workers and felt that "it got dumped on them". In her county, only three of the ten ES workers had attended MAPP training.

Milwaukee representatives were particularly frustrated with the inability of a MAPP applicant to reach an ES worker to discuss MAPP enrollment. They recounted stories of applicants being bounced back and forth between the toll-free Medicaid recipient hotline and the county as they tried to have their questions answered. They also indicated that

phones at county offices often went unanswered and that ES worker voice mail boxes were often full.

Two MAPP policies were also identified as barriers to enrollment – the premium structure and the work requirement. PTI specialists felt that MAPP premiums were unaffordable for individuals who had high levels of unearned income relative to their earned income (e.g. individuals receiving SSDI payments). While the workers appreciated certain aspects of the work requirement, such as the flexible definition of "work", there were concerns about other aspects of the work policies. These concerns focused on the work exemption policies. MAPP recipients are eligible for a six-month exemption. However, this exemption is limited to individuals who have been in the program for at least six months and participants are limited to two exemptions every three years.

These policies were considered to be inflexible given the health needs of the eligible population. This is a population that frequently gets sick and may need to take off work for a period of time. A suggestion was made to modify the requirement so that individuals would be required to work for at least six months out of the year to qualify for MAPP (i.e. allow for a total of six months of work exemptions in each year).

Concerns were also raised regarding the requirement to obtain a disability determination from the Disability Determination Bureau (DDB) before enrolling in MAPP. The DDB has been instructed by the federal Department of Health and Human Services to disregard evidence of a substantial gainful activity (SGA) when completing the disability determination process. This is a critical directive given that working or moving toward employment through HEC are MAPP program requirements. A number of representatives recounted instances in which it appears that the DDB disregarded this directive so that there were applicants who were wrongly denied a disability determination and were consequently unable to enroll in MAPP.

The session concluded with a series of comments on HEC. Some individuals expressed a belief that HEC screeners who were not also PTI Benefit Specialists do not have sufficient training to identify realistic work goals for the MAPP population. Another representative indicated that a recipient was having a difficult time reaching his/her HEC counselor. CDSD were aware of these concerns and worked on a number of improvements to the HEC program in past few months. A full description of the improvements is included in the section "HEC Program Improvements".

Other County Comments

The primary concern expressed by individuals at the Long-Term Care and Aging Conference in April was the lack of training on Medical and Remedial Expenses (MREs) and Impairment-Related Work Expenses (IRWEs). Comments at the meeting suggest that ES workers are not using consistent criteria for determining MREs and IRWEs for MAPP. It was also suggested that MREs should be standardized across all Medicaid subprograms. There does appear to be overlap between what is characterized as an IRWE

and what is characterized as an MRE. Items such as prescription drugs and bus passes for work are identified as both on program materials.

The current guidance for classifying IRWE expenses is somewhat vague. The MAPP Handbook states that IRWE expenses are to be limited to costs related to one's disability and employment. They cannot be an expense that a similar worker without a disability would have, such as uniforms. The Handbook provides the following examples of IRWEs:

- Durable medical equipment
- Seeing-eye dogs
- Prostheses
- Prescription drugs

The MAPP Consumer Guide provides very different examples of IRWEs, including but not limited to:

- Attendant care services
- Job coaching
- Interpreter
- Workspace accommodations
- Reading aids

The Consumer Guide examples are more consistent with the MAPP Handbook definition of an IRWE and are more readily distinguishable from MRE expenses.

HEC Program Improvements

As was previously discussed, initially, the HEC program utilized local screeners to assess the completeness and manageability of each applicant's employment plan. A total of 160 screeners were trained, representing employees of county economic support agencies, vocational rehabilitation programs and Pathways to Independence service sites. The HEC screening process was not funded by the state Department of Health and Family Services. Each screener conducted HEC screenings as an additional, unpaid, activity. In addition to evaluating each applicant's employment plan, many screeners have also assisted applicants with employment plan development.

During the first year of the MAPP program, it became evident that the HEC screening process required re-visiting based upon the relatively small number of enrollees who entered the MAPP program via the HEC screening process. As of June 30, 2001, approximately 35 applicants had enrolled in the MAPP program by way of the HEC screening process. Employment Resources, Inc.(ERI) identified the following factors as contributing to limited MAPP enrollment through the HEC program:

- HEC screeners have full-time duties with their employers and do not have a strong identification with the program,
- Insubstantial and ineffective marketing support for MAPP or HEC,

- Limited outreach to the disability community, and
- Insufficient availability of benefits analysis and planning.

In addition to the reasons cited above, the majority of the screeners had only a cursory understanding of benefits analysis and benefits planning as they relate to individuals with disabilities. Also, as unpaid assistants the screeners had not been asked to serve consumers that were not clients of their agencies or to engage in HEC program outreach.

In response to low MAPP enrollment through the HEC program, ERI proposed a new HEC screening process for year two of the MAPP program. The revised screening process consists of seven Regional HEC Screeners, devoting approximately .2 FTE each under a subcontract with ERI. All screening procedures are to be coordinated by a Statewide HEC Coordinator employed by ERI. Year one HEC screeners can continue to participate in the HEC screening process in year two, acting as HEC Liaisons. In addition, current PTI Benefit Specialists will continue to provide screening services in year two.

Unlike many year one screeners, all Regional Screeners have experience with disability benefits issues, benefits analysis and counseling, service and supports available to disabled consumers, and familiarity with disability employment barriers. Specific responsibilities of the Statewide HEC Coordinator, Regional HEC Screeners and Local HEC Liaisons, as outlined by ERI, include the following:

Statewide HEC Coordinator

- Coordinate the activities of the Regional HEC Screeners
- Provide initial and ongoing training for Regional HEC Screeners
- Provide technical assistance to Regional HEC Screeners and Local Liaisons, e.g., Pathways benefit specialists

Regional HEC Screeners

- Conduct outreach within their local area to consumer/family groups, service providers, county agency personnel, schools, etc.
- Team with the Local HEC Liaisons to conduct a screen; co-sign plan
- Provide benefit analysis to HEC enrollees
- Provide benefits analysis to MAPP enrollees who cannot access benefits counseling
- Make follow-up contact with Local HEC Screeners to determine progress
- Conduct independent screens and benefit analyses for individuals who do not have access to a Local HEC Liaison

Local HEC Liaison

- Make referrals to the Regional HEC Screener
- Facilitate the screen by teaming with the Regional HEC Screener; co-sign screen
- Submit the HEC Screen paperwork to DHFS
- Provide follow-up information to Regional HEC Screener

The HEC screening process is an important portal through which disabled individuals can access the MAPP program. As such, the changes proposed above are intended to increase MAPP enrollment through HEC screenings. Utilization of Regional HEC Screeners with extensive knowledge of disability benefits analysis and planning should provide a more effective and efficient screening process for enrollment in the MAPP program. Enrollment trends will be tracked in year two of the MAPP program, focusing on enrollment through HEC screenings. The effectiveness of the HEC screening modifications will be evaluated during the year and reported in the year two Annual Evaluation Report.

VII. Summary

While it is too soon to measure the impact of MAPP on participants' ability to earn more money without fear of losing health insurance and to save toward independence, it appears that the program is on track toward meeting these goals. The fact that the majority of MAPP enrollees were previously receiving health care coverage through non-MAPP eligibility criteria, suggests that MAPP has allowed some Medicaid recipients to earn more or retain higher assets without losing their Medicaid coverage.

The third goal of the program – to offer an effective, efficient and equitable program has been more of a challenge over the last year. Beginning when the program was implemented without county eligibility staff having received MAPP training, the administration of the program has been disjointed at the county level. County staff have exhibited varying levels of understanding regarding program policies and have demonstrated different levels of accuracy in completing the application forms. As a result, MAPP applicants may have been incorrectly denied coverage or may have been charged the wrong premium amount. In some counties, particularly Milwaukee County, the lack of understanding about basic program requirements and the inability to reach an ES Worker has prevented some potential applicants from accessing the program. County staff have also identified a need for additional outreach to identify and enroll more people who may be eligible for the program.

While many of the administrative issues will be resolved with the automation of MAPP eligibility in CARES, BHCE may want to consider providing additional training or program information to the ES Workers. Even with automation where the computer will do most of the calculations, ES Workers may need to possess a good understanding of the underlying logic, such as what "counts" toward the determination of premium liability so that they are able to accurately describe the program to applicants. BHCE may also want to provide additional clarification in the Handbook on the policies where there seems to be the most confusion (i.e. what counts as an IRWE).

One way to address confusion about program policies among MAPP applicants, participants and other stakeholders would be to revise the MAPP Consumer Guide. For example, the state may want to consider modifying the Guide so that it provides more guidance on what to do if you lose your job. The Guide provides examples of what to do if you can't work due to illness or if you lose eligibility as a result of failure to pay premiums, but it does not explain how a gap in employment would be treated if a individual were to change jobs. A participant has until the last day of the next calendar month to become employed if they lose employment. This information was provided to the counties last July, but it is not in the Consumer Guide.

Based on the feedback from counties, the State may also want to consider studying alternative work exemption policies to better meet the needs of the working disabled population. The current policy provides coverage for individuals who may have infrequent, but extensive periods of illness that prevent them from working. Pathways Benefits Specialists who have been working with this population suggest that they would

be better served by a policy that protects the participants for more frequent, but shorter periods of illness that prevent them from working.

The State is already in the process of evaluating and considering alternatives to the current premium formula. One proposal being considered that would mirror the premium calculation used for the BadgerCare program and eliminate the differential treatment of earned and unearned income. Regardless of the final structure of the premium formula, as long as ES Workers are inconsistent in their application of the new premium program inequities will persist. It is not clear how the state will address existing cases where applicants have not had their premium calculated properly over the last year using the existing formula.

Other areas that may warrant special attention in the next year are the HEC component of the program and the Independence Accounts. These are two benefits developed specifically for the MAPP program and it is not clear if they are being fully or correctly utilized. Given the very low numbers of Independence Account registrations on file with the state, the counties may also need to be reminded to submit these to the state. Finally, a better understanding of the disability status of the MAPP population is needed to understand why COP to COP-W conversions have been less than expected.

VIII. Appendix

Attachment A: Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	**To**	**Premium**	**From**	**To**	**Premium**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

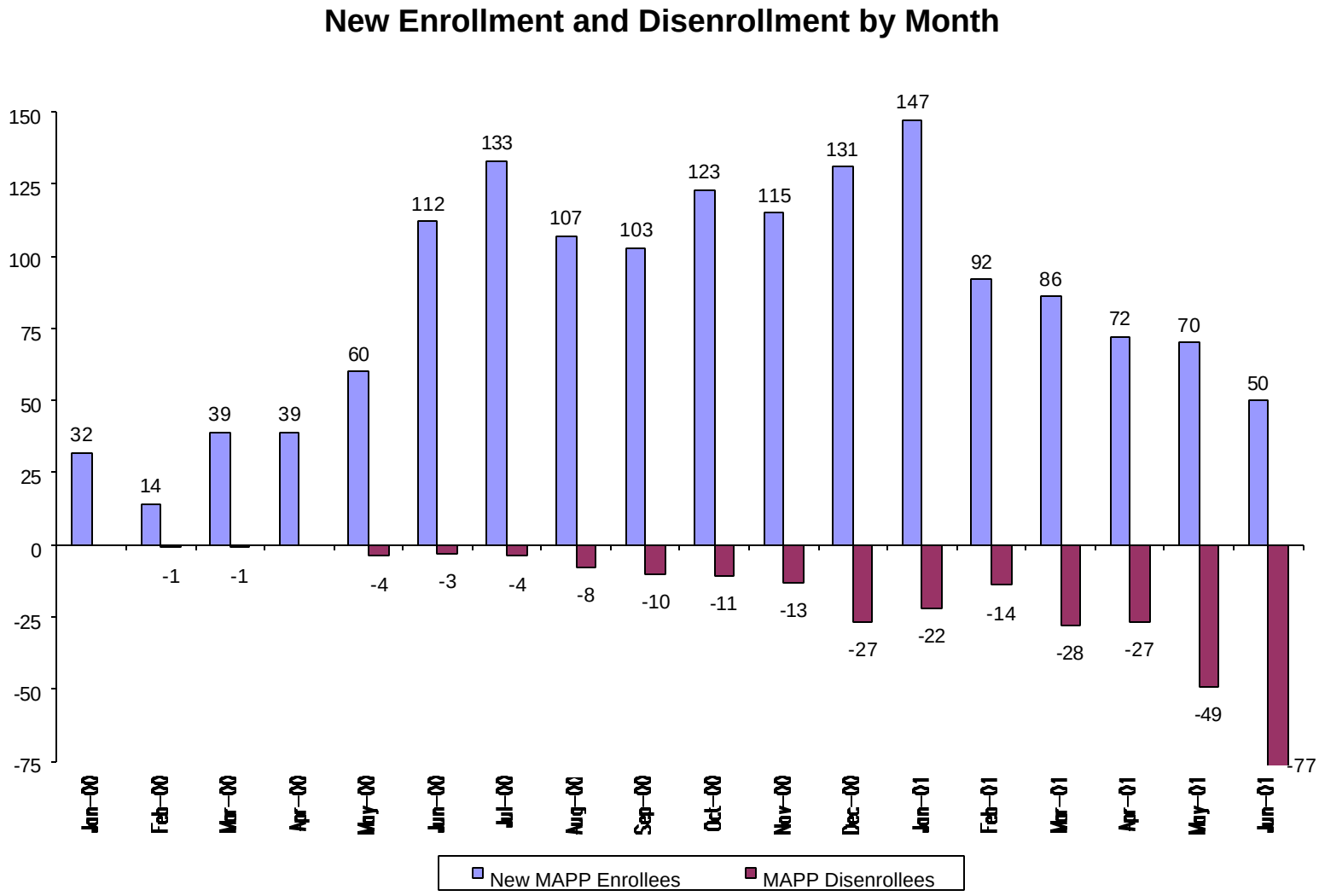
Attachment B: Eligibility Trends for MAPP Enrollees

Month of Year	New MAPP Enrollees[1]	# With Eligibility Prior Month[2]	% With Eligibility Prior Month[2]	# With Any Prior Eligibility[3]	% With Any Prior Eligibility	# With Post MAPP Eligibility[5]	MAPP Disenrollees[6]	MAPP Net New Enrollees[7]
01-Jan-00	32	7	21.9%	24	75.0%	6	0	32
01-Feb-00	14	5	35.7%	9	64.3%	5	1	13
01-Mar-00	39	19	48.7%	31	79.5%	9	1	38
01-Apr-00	39	17	43.6%	30	76.9%	11	0	39
01-May-00	60	32	53.3%	49	81.7%	10	4	56
01-Jun-00	112	66	58.9%	92	82.1%	24	3	109
01-Jul-00	133	81	60.9%	114	85.7%	25	4	129
01-Aug-00	107	59	55.1%	91	85.0%	20	8	99
01-Sep-00	103	52	50.5%	88	85.4%	18	10	93
01-Oct-00	123	71	57.7%	104	84.6%	13	11	112
01-Nov-00	115	76	66.1%	96	83.5%	12	13	102
01-Dec-00	131	105	80.2%	120	91.6%	12	27	104
01-Jan-01	147	85	57.8%	124	84.4%	14	22	125
01-Feb-01	92	59	64.1%	80	87.0%	5	14	78
01-Mar-01	86	61	70.9%	78	90.7%	7	28	58
01-Apr-01	72	46	63.9%	64	88.9%	4	27	45
01-May-01	70	49	70.0%	64	91.4%	3	49	21
01-Jun-01	50	39	78.0%	46	92.0%	0	77	-27
Sums:	**1525**	**929**	**60.9%**	**1,304**	**85.5%**	**198***	**299**	**N/A**
						Total Current Enrollment:		**1,300 ****

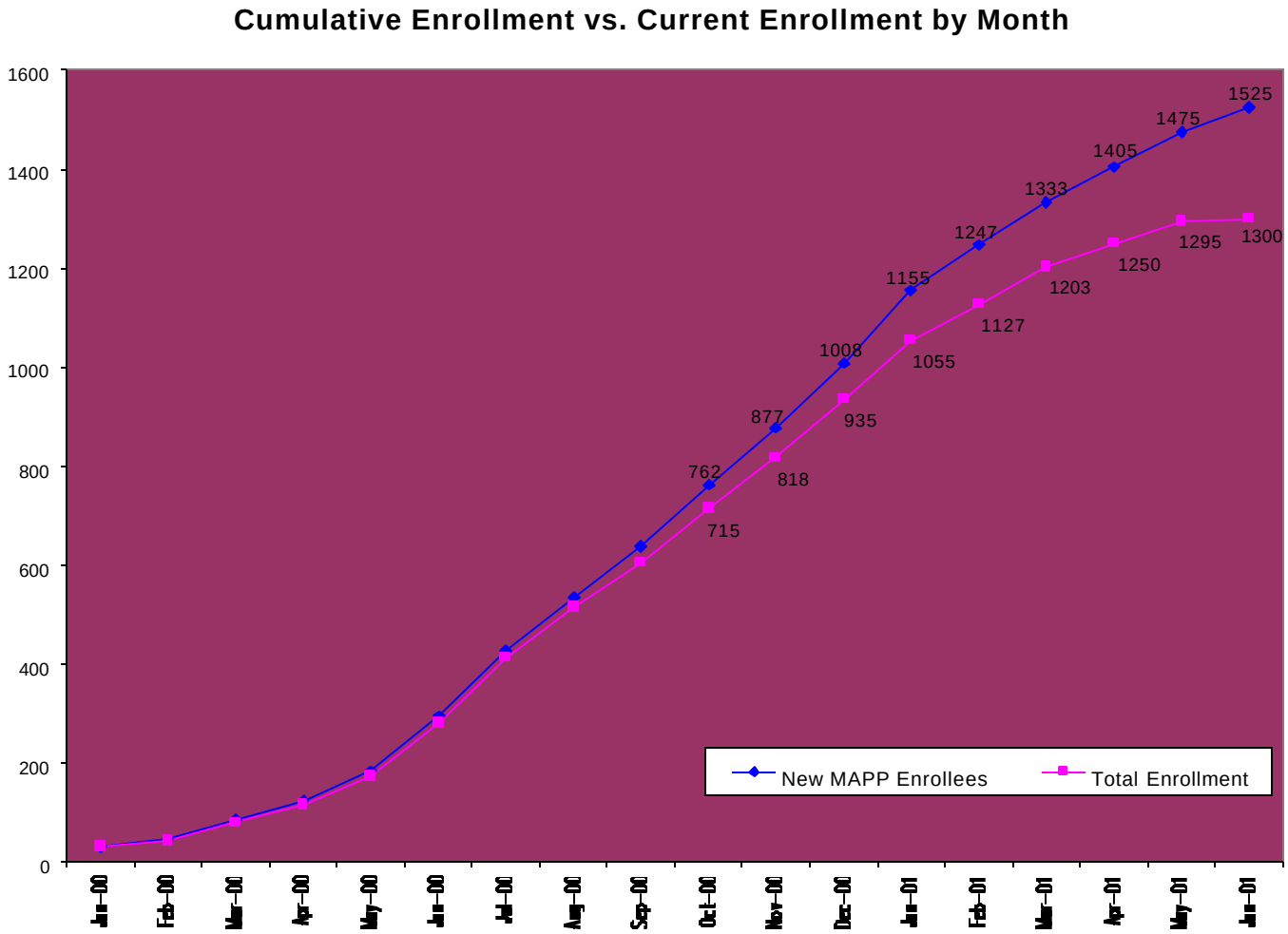
[1] The minimum MAPP enrollment date for an individual
[2] Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date
[3] Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date
[5] Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date
[6] The maximum MAPP end date for an individual (most recent disenrollment)
[7] New MAPP enrollees minus MAPP disenrollees

* Ex-MAPP enrollees were assigned to the medical status groups of their first post-MAPP eligibility segment.
** The MAPP Net New Enrollees figure is based on the first MAPP eligibility segment. The Total Current Enrollment includes those individuals who re-enrolled after leaving MAPP.
Note: Data for this table was run on 7/17/01

Attachment C: New Enrollment and Disenrollment by Month



Attachment D: Cumulative Enrollment vs. Current enrollment by Month



Attachment E: County Breakdown of Disabled Medicaid Enrollees versus MAPP Enrollees

County Breakout of Disabled Medicaid Enrollees versus MAPP Enrollees (Enrollment data as of June 30, 2001

Total Disabled Medicaid Enrollees (including MAPP)		
County	**Count**	**% of Total**
Milwaukee	46762	28.93%
Dane	9100	5.63%
Racine	5885	3.64%
Brown	5173	3.20%
Rock	4727	2.92%
Waukesha	4429	2.74%
Kenosha	4030	2.49%
Winnebago	3705	2.29%
Marathon	3510	2.17%
La Crosse	3355	2.08%
Outagamie	3007	1.86%
Eau Claire	2988	1.85%
Sheboygan	2726	1.69%
Fond du Lac	2520	1.56%
Wood	2340	1.45%
Manitowoc	2326	1.44%
Waupaca	2236	1.38%
Barron	2073	1.28%
Douglas	1959	1.21%
Jefferson	1888	1.17%
Chippewa	1851	1.15%
Walworth	1810	1.12%
Grant	1790	1.11%
Dodge	1685	1.04%
Marinette	1650	1.02%
Portage	1589	0.98%
Washington	1542	0.95%
Sauk	1501	0.93%
Oneida	1298	0.80%
Columbia	1274	0.79%
Monroe	1262	0.78%
Trempealeau	1224	0.76%
Shawano	1221	0.76%
Clark	1180	0.73%
Polk	1121	0.69%
Dunn	1110	0.69%
St. Croix	1100	0.68%
Lincoln	1032	0.64%
Vernon	1025	0.63%
Juneau	977	0.60%
Oconto	964	0.60%
Ashland	926	0.57%

MAPP Enrollment		
County	**Count**	**% of Total**
Dane	173	13.21%
Milwaukee	63	4.81%
Marathon	61	4.66%
Winnebago	61	4.66%
Outagamie	58	4.43%
Kenosha	46	3.51%
Sheboygan	41	3.13%
La Crosse	39	2.98%
Waukesha	39	2.98%
Wood	37	2.82%
Fond du Lac	34	2.60%
Brown	34	2.60%
Washburn	33	2.52%
Washington	33	2.52%
Ozaukee	28	2.14%
Racine	27	2.06%
Eau Claire	26	1.98%
Portage	24	1.83%
Rock	23	1.76%
Ashland	22	1.68%
St. Croix	20	1.53%
Green	19	1.45%
Trempealeau	19	1.45%
Grant	18	1.37%
Jefferson	18	1.37%
Marinette	17	1.30%
Barron	16	1.22%
Clark	14	1.07%
Monroe	14	1.07%
Sauk	13	0.99%
Adams	12	0.92%
Shawano	11	0.84%
Chippewa	11	0.84%
Douglas	11	0.84%
Manitowoc	11	0.84%
Calumet	10	0.76%
Dunn	10	0.76%
Waupaca	10	0.76%
Pierce	9	0.69%
Taylor	9	0.69%
Walworth	9	0.69%
Door	8	0.61%

Total Disabled Medicaid Enrollees (including MAPP)		
County	**Count**	**% of Total**
Langlade	896	0.55%
Ozaukee	874	0.54%
Green	823	0.51%
Jackson	776	0.48%
Rusk	767	0.47%
Washburn	764	0.47%
Price	762	0.47%
Waushara	761	0.47%
Crawford	756	0.47%
Taylor	744	0.46%
Sawyer	729	0.45%
Adams	681	0.42%
Richland	678	0.42%
Pierce	651	0.40%
Vilas	596	0.37%
Door	585	0.36%
Burnett	577	0.36%
Green Lake	543	0.34%
Calumet	542	0.34%
Bayfield	507	0.31%
Buffalo	495	0.31%
Iowa	491	0.30%
Kewaunee	463	0.29%
Forest	460	0.28%
Marquette	431	0.27%
Lafayette	386	0.24%
Iron	347	0.21%
Pepin	277	0.17%
Menominee	226	0.14%
Florence	188	0.12%
Unknown	3	0.00%
N/A	1	0.00%
Total	161,651	

MAPP Enrollment		
County	**Count**	**% of Total**
Columbia	8	0.61%
Iowa	7	0.53%
Sawyer	7	0.53%
Rusk	7	0.53%
Jackson	7	0.53%
Langlade	7	0.53%
Oneida	7	0.53%
Bayfield	6	0.46%
Price	6	0.46%
Green Lake	5	0.38%
Lincoln	5	0.38%
Dodge	5	0.38%
Burnett	4	0.31%
Crawford	4	0.31%
Juneau	4	0.31%
Vernon	4	0.31%
Florence	3	0.23%
Marquette	3	0.23%
Kewaunee	3	0.23%
Waushara	3	0.23%
Pepin	2	0.15%
Lafayette	2	0.15%
Vilas	2	0.15%
Richland	2	0.15%
Oconto	2	0.15%
Polk	2	0.15%
Iron	1	0.08%
Buffalo	1	0.08%
Unknown	0	0.00%
Forest	0	0.00%
Menominee	0	0.00%
N/A	0	0.00%
Total	1,310	

Note: Disabled Medicaid enrollees includes individuals with the following med stat codes:

01,02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 28, 40, 41, 42, 43, 44, 45, 46, 47, 90, 91, 92, 93, A1, A2, AD, BD, 5C, 6C, 5D, 6D, DC, DD, DN, IC, IM, L1, L2, L3, L4, L5, L6, L7, L8, M3, M4, M5, M6, M7, M8, M9, MP, Q1, Q2, QN, QR, QW, RC, RN, SB W2, W3, W4, W5, W6, WA, WB, WC, WP, WR, WI, WW, ZN, ZZ

Attachment F: MAPP Enrollment by Premium Status

MAPP Enrollment by Premium Status
SFY 2001 (July 1, 2000 – June 30, 2001)

Benefit Month	Enrollees With Premium Med Stat Code	Enrollees Without Premium Med Stat Code	Total Enrollment	% of Total With Premium Med Stat Codes
July 2000	66	347	413	16.0%
August 2000	87	429	516	16.9%
September 2000	103	502	605	17.0%
October 2000	124	591	715	17.3%
November 2000	149	669	818	18.2%
December 2000	170	765	935	18.2%
January 2001	196	859	1055	18.6%
February 2001	216	911	1127	19.2%
March 2001	237	966	1203	19.7%
April 2001	247	1,003	1250	19.8%
May 2001	252	1,043	1295	19.5%
June 2001	251	1,049	1300	19.3%

Note: MAPP premium payments are used as the state match to claim additional federal Medicaid dollars. In state fiscal year 2000-01, every $1 in premium revenue generated approximately $1.45 in federal Medicaid revenues.

Attachment G: MAPP Premium Payment History

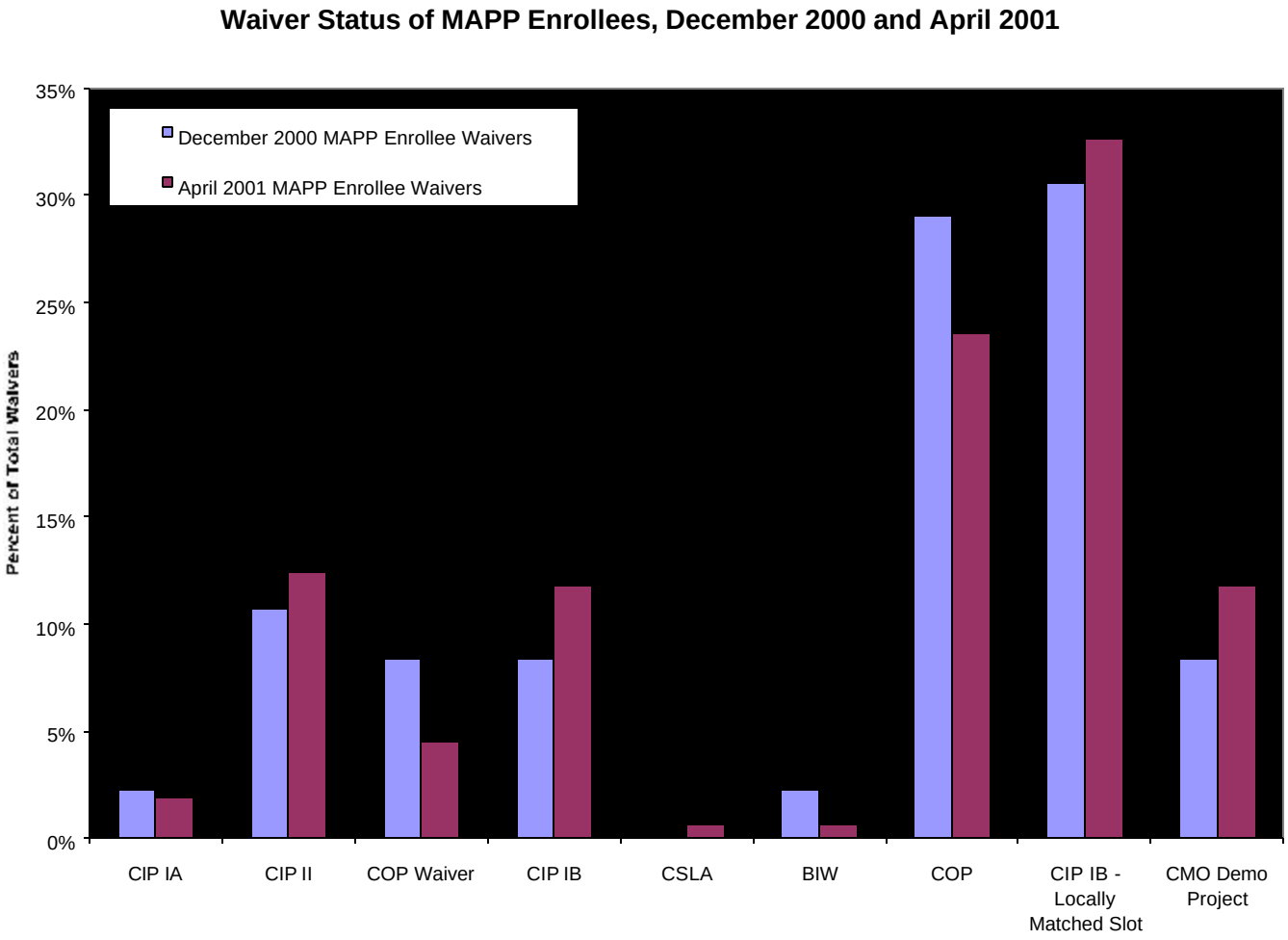
MAPP Premium Payment History

Total Premium Payments Received January 1, 2000 – June 30, 2001
$198,905

Total Premium Payments Received July 1, 2000 – June 30, 2001
$191,555

Benefit Month	Payments Received	Average Payment	Minimum Payment	Maximum Payment	Total Paid Claims	Premiums as % of Claims
July 2000	$ 6,300	$ 98.33	$ 10	$ 475	$ 188,442	3.34%
August 2000	$ 7,775	$ 96.08	$ 10	$ 625	$ 232,560	3.34%
September 2000	$ 8,050	$ 83.20	$ 10	$ 625	$ 257,428	3.13%
October 2000	$ 10,950	$ 93.88	$ 10	$ 675	$ 291,204	3.76%
November 2000	$ 12,775	$ 93.57	$ 10	$ 675	$ 341,585	3.74%
December 2000	$ 15,300	$ 97.69	$ 10	$ 675	$ 419,479	3.65%
January 2001	$ 19,100	$ 104.40	$ 10	$ 675	$ 524,940	3.64%
February 2001	$ 21,000	$ 105.02	$ 10	$ 675	$ 595,620	3.53%
March 2001	$ 21,605	$ 102.34	$ 5	$ 675	$ 627,785	3.44%
April 2001	$ 22,775	$ 102.73	$ 10	$ 675	$ 588,539	3.87%
May 2001	$ 23,850	$ 107.82	$ 10	$ 675	$ 581,832	4.10%
June 2001	$ 22,075	$ 120.88	$ 10	$ 575	$ 459,650	4.80%

Attachment H: Waiver Status of MAPP Enrollees, December 2000 and April 2001



Attachment I: Waiver Status of MAPP Enrollees

Waiver Status of MAPP Enrollees

Monthly MAPP enrollees % of	December 2000	April 2001
MAPP enrollees with waivers	935	1250
	13.0%	11.7%

LTS Code	LTS Name	December 2000 MAPP enrollees with December 2000 waivers[1]	% of Total December 2000 waivers	April 2001 MAPP enrollees with April 2001 waivers[2]	% of Total April 2001 waivers
1	CIP IA	3	2.3%	3	2.0%
2	CIP II	14	10.7%	19	12.4%
3	COP Waiver	11	8.4%	7	4.6%
4	CIP IB	11	8.4%	18	11.8%
5	CSLA	0	0.0%	1	0.7%
6	BIW	3	2.3%	1	0.7%
7	COP	38	29.0%	36	23.5%
8	CIP IB - Locally Matched Slot	40	30.5%	50	32.7%
C	CMO Demo Project	11	8.4%	18	11.8%
	Sum of all waivers	131		153	
	Unduplicated Enrollee Count[3]	122		146	

[1] MEDS eligibility data was queried to find December 2000 MAPP enrollees. HSRS LTS data was then queried to identify those MAPP enrollees who also had waiver eligibility in December 2000.

[2] Because counties submit HSRS data on a monthly basis volunatarily, at the time of this writing, April 2001 is the most recent month for which there appears to be complete HSRS waiver data. Please note that counties are only required to submit HSRS data annually on a calendar year basis. Consequently, December 2000 is the most recent month for which there is definitively complete data (i.e. data for all Wisconsin counties).

[3] A number of MAPP enrollees were eligible for more than one waiver in a given month.

Attachment J: Waiver Status of MAPP enrollees with Multiple Waivers

Waiver Status of MAPP Enrollees with Multiple Waivers

December 200						April 2001				
	CIP II	CIP IB	COP W	COP			CIP II	CIP IB	COP W	COP
9810	x		x	x	<-same person ->	9810	X			x
1210			x	x	<-same person ->	1210			x	x
5800	x			x	<- same person ->	5800	X			x
9690	x			x	<-same person ->	9690	X			x
6760		x		x	<-same person ->	6760		x		x
4490	x		x			9980			x	x
2710	x		x			4750	X			x
1850			x	x						

75% of those with multiple waivers have COP.
63% have CIP II

Most common combo: CIP II and COP (75%)

100% of those with multiple waivers have COP
57% have CIP II

Most common combo: CIP II and COP (38%)

Attachment K: Job Goals from HEC Employment Plans

Job Goals from HEC Employment Plans

Job Goal Category	Number of Individuals Listing Goal	and % of Total
Computer or General Office Work	14	40%
Assembly or Manufacturing Work	10	29%
Janitorial or Maintenance Work	9	26%
Customer Service, Marketing	8	23%
Retail and Sales	6	17%
Driver (Forklift, Delivery, Taxi, etc)	6	17%
Food Service	5	14%
Human and Health Services	4	11%
Other	10	29%

Note: Other includes: Salvation Army bell ringing, real estate, writer, sheriff, beautician, cosmetology, stocking, special education teacher, technical education teacher and Punett Press operator..

Attachment L: MAPP Application worksheets

Attachment M: Summary of Returned MAPP Applications by County

Summary of Returned MAPP Applications by County as of July 16, 2001

County/Agency Name	Not Sent	Received	Grand Total	% Returned
ADAMS	5	6	11	55%
ASHLAND	11	12	23	52%
BARRON	11	15	26	58%
BAYFIELD	6		6	0%
BCR	1		1	0%
BROWN	4	36	40	90%
BUFFALO	1		1	0%
BURNETT	4	1	5	20%
CALUMET	5	7	12	58%
CHIPPEWA	14		14	0%
CLARK	6	9	15	60%
COLUMBIA	2	9	11	82%
CRAWFORD	2	3	5	60%
DANE	62	138	200	69%
DODGE	2	7	9	78%
DOOR	11		11	0%
DOUGLAS	6	10	16	63%
DUNN	15	1	16	6%
EAU CLAIRE	30	1	31	3%
FLORENCE	1	3	4	75%
FOND DU LAC	10	26	36	72%
GRANT	7	17	24	71%
GREEN	11	10	21	48%
GREEN LAKE	5	1	6	17%
IOWA	1	8	9	89%
IRON	1	1	2	50%
JACKSON		9	9	100%
JEFFERSON	18	1	19	5%
JUNEAU	1	5	6	83%
KENOSHA	29	22	51	43%
KEWAUNEE		4	4	100%
LACROSSE	20	30	50	60%
LAFAYETTE		2	2	100%
LANGLADE	2	9	11	82%
LINCOLN		6	6	100%
MANITOWOC	9	5	14	36%
MARATHON	19	51	70	73%
MARINETTE	4	15	19	79%
MARQUETTE	3		3	0%
MENOMINEE	1		1	0%
MILWAUKEE	81	7	88	8%
MONROE	11	7	18	39%
OCONTO		3	3	100%
ONEIDA	4	3	7	43%
OUTAGAMIE	14	50	64	78%
OZAUKEE	10	20	30	67%
PEPIN		2	2	100%

County/Agency Name	Not Sent	Received	Grand Total	% Returned
PIERCE	1	10	11	91%
POLK	1	1	2	50%
PORTAGE	4	21	25	84%
PRICE	10		10	0%
RACINE	13	17	30	57%
RICHLAND	1	1	2	50%
ROCK	14	15	29	52%
RUSK	1	9	10	90%
SAUK	18		18	0%
SAWYER	2	8	10	80%
SHAWANO	10	1	11	9%
SHEBOYGAN	32	15	47	32%
SSI/MA - MARATHON		1	1	100%
SSI/MA - ST. CROIX	1		1	0%
SSI/MA - WAUKESHA	1		1	0%
SSI/MA - WOOD	1		1	0%
ST. CROIX	10	13	23	57%
TAYLOR	4	8	12	67%
TREMPEALEAU	5	18	23	78%
VERNON	3	2	5	40%
VILAS	1	1	2	50%
WALWORTH	3	10	13	77%
WASHBURN	17	16	33	48%
WASHINGTON	4	31	35	89%
WAUKESHA	18	29	47	62%
WAUPACA		12	12	100%
WAUSHARA	4	3	7	43%
WINNEBAGO	24	45	69	65%
WOOD	17	22	39	56%
Grand Total	**680**	**881**	**1561**	**56%**

Attachment N: Summary of County Telephone Interviews

Summary of County Telephone Interviews

Interviews were conducted from June 20, 2001 through June 28, 2001 with individuals from the following counties: Dane County, LaCrosse County, Marathon County, Milwaukee County and Sheboygan County

How is the MAPP program supposed to work? (4 answers)

Most interviewed talked about the overall goal of the program to expand coverage. More specifically, three stated that MAPP helps people with **disabilities**. Half mentioned the ability of the program to help **working** people or those with more income/assets than MA allows. One talked about the **outreach** component of the program—specifically using brochures and fliers to encourage people to apply.

One interviewee approached the question from a more administrative view, explaining how MAPP **eligibility** is determined by ES workers who submit the documents to the State.

How is it working? (5 answers)

Most people interviewed feel the program is working for those people it reaches. Two feel that more **outreach** is needed to identify and enroll more persons who may be eligible. Three mention the **administrative burden** of the 'very cumbersome…certification process', the 'labor-intensive entry process', and the 'paper and time intensive' enrollment. One specifically mentions the absence of resource allocation to expand staff to meet MAPP needs. Finally, one interviewee feels the **premiums** and out of pocket costs deter some potential enrollees.

Who will it help? (4 answers)

All respondents agree MAPP will help the **working disabled**, but disagree on which subset of the disabled it will help most. Two feel that the maximum benefit will be for those with mental or physical disabilities, while one feels the developmentally disabled will benefit most. Finally, one interviewee states that **healthcare facilities** will benefit from MAPP.

Has it helped people in your county? (5 answers)

All agree that MAPP has helped people in their community, all subgroups of the disabled (developmental, mental, physical) are mentioned.

What is wrong with the program? (5 answers)

Administrative burden and **complexity** are consensus 'wrongs' with the program. Specifically, the complexity affects the ability of staff to learn the program and navigate the system. One respondent reiterates that the administrative burden of MAPP was placed on the counties with no additional staff resources allocated. Difficulty obtaining a Health and Employment Counseling referral was specified by one respondent.

Another agreed upon weakness in MAPP is **outreach and publicity**---to both potential enrollees and medical and social service workers (social workers). TV ads and medical waiting room ads are suggested.

Has MAPP helped you shift funding for long term care services from the county to Federal and State sources? (4 answers)

The jury is still out; one says yes, one thinks yes—but can't prove it, one is unsure, and one says no.

What is the dollar amount of funds shifted? How did you identify the savings? (2 answers)

Again, uncertainty prevails. No specific figures or methodology is given. Further follow-up needed.

How do you track the money spent on each recipient? (2 answers)

Each of the two respondents mention an internal data system that is used primarily to generate reports for the State. Neither appears to do any county-level analysis.

Have you engaged in any outreach efforts to enroll people in MAPP? (5 answer)

All respondent counties do some outreach, however it seems somewhat **limited** and non-systematic. Two have met with healthcare facilities, two have met with community agencies, and two mention pamphlets and brochures.

Do you feel MAPP has the potential to impact your county's ability to serve the disabled? (5 answers)

All agree.

What Community Aids programs has MAPP had the greatest impact on? (3 answers)

Impact specific to county. One county noted significantly increased enrollment in COP-W, one mentioned increased enrollment in CIP-1B, the third refered to Mental Health Community Support.

Has MAPP helped any non-Medicaid people obtain coverage? (5 answers)

Four yes, one unsure—no details.

Are the financial requirements realistic regarding earned and unearned income? (4 answers)

All respondents agree that they are fair. However, one notes that two people with the same amount of cash flow could be required to pay different premiums (because of differences in the treatment of unearned and earned income).

Are there waiting lists in your county for waiver programs? (3 answers)

The three counties that responded (Sheboygan, Dane, Marathon) all admit to waiting lists for various programs. Dane's largest lists are for COP and COP-W, Sheboygan's largest is for those with developmental disabilities, and Marathon didn't specify.

What is the largest barrier to enrolling people in MAPP? (5 answers)

Again, the issues of poor public awareness/lack of outreach and administrative burden/program complexity **prevail in all responses.**

Attachment O: MAPP Evaluation Survey Administration and Method

A number of surveys have been developed to collect process, impact and fiscal information that is not available from existing administrative databases.

Recipient Survey

Two versions of a MAPP participant survey have been developed. The first, or "Initial Survey," was designed to be administered to individuals who are new to the MAPP program. The second, or "Follow-up Survey," was designed to be administered to participants at 6, 12 and 24 months after enrollment. Once a sample has been drawn, a hard copy of the survey is mailed to each of the sample participants, with a cover letter describing the evaluation project and inviting the participant to assist in the evaluation effort by participating in the study. The list of sample names, with addresses and phone numbers, is transmitted electronically to the interviewer in an MS Access database. Several days after the surveys and letters are mailed, the interviewers begin making phone calls to each of the sample participants. If contact is made, and the participant agrees, the survey questions are completed over the telephone and the answers are entered directly into the Access database. When calls to each cohort are complete, the database is transmitted back to evaluation staff for analysis.

Recipient Survey Field Test

The MAPP Initial and Follow-Up surveys were field tested in mid-February, 2001. The survey was mailed to a sample of 20 MAPP participants. Evaluation staff attempted a telephone contact with each of those 20 participants. A total of five surveys were completed over the telephone. Answers were entered into the Access database and minor changes to both the database and the survey instrument were made based on the field test.

Recipient Survey Administration

Surveys were mailed to the first cohort of MAPP participants in late February. Subsequent cohorts were drawn monthly, beginning in April 2001. Each cohort consists of two groups – new MAPP enrollees receiving the Initial Survey, and participants receiving the Follow-up Survey. A more detailed description of the sample is provided later in this section.

The first cohort of interviews began in early March 2001. After two weeks of calling, the results todate were assessed and several obstacles to completing the surveys were identified. First, most of the phone calls resulted in no contacts. Approximately 25% of the sample participants' records did not contain telephone numbers, so telephone contact was not possible. In addition, many of the telephone numbers in the records were inaccurate (e.g. disconnected) or were for another individual, such as a guardian or a group home staff manager.

As a result, the following protocol was established for attempting to contact survey recipients. A total of five attempts are made to contact each sample participant. At least two of the five attempts are made after 5:00 p.m. on weekdays or on Saturday. When contact is made, the participant is invited to complete the survey questions at that time, or

to schedule another time for the interviewer to call back and complete the survey. If the participant does not wish to complete the survey on the telephone, he/she is offered the option of completing the survey and mailing it back. A postage paid return envelope is then mailed to the participant to facilitate compliance. When contact is made with another individual who knows the participant well, such as a family member, social worker, or guardian, the interviewer offers that person the option of completing the survey on the participant's behalf, or helping the participant complete the survey.

For participants for whom the records contain no accurate telephone number, a second letter is mailed, with a return envelope, inviting them to either complete and return the survey by mail, or call the interviewer to schedule a time to complete the survey via telephone. In July 2001 this protocol was revised when evaluation staff obtained access to the CARES system, which provided a more reliable source for contact information. Through CARES, evaluation staff was able to obtain telephone numbers for over 90% of the June 2001 sample. We have not yet collected enough data to determine the accuracy of the CARES-generated telephone numbers. The follow-up letter described above will continue to be sent to the remaining participants for whom there is no accurate telephone number.

Recipient Survey Progress To Date

As of July 27, 2001, the following progress had been made on the administration of the Initial and Follow-up Surveys**.** The Initial Survey has been mailed to 224 people and the Follow-up Survey has been mailed to 193 (double check). The table below summarizes the response rates for those participants for whom all contact attempts have been exhausted to date, for each survey.

Response	Initial Survey Percentage n=224	Follow-Up Survey Percentage n=193	Combined Percentage
Survey Completed	36%	32%	34%
Refused*	25%	21%	23%
No Telephone Listing	27%	35%	31%
No Contact (5 attempts)	12%	12%	12%

*** "Refused" includes participants who told the interviewer they would mail in the survey, but failed to do so.**

Please note that the Survey Completed rate increases to 49% across both surveys when the "No Telephone Listing" participants are removed from the calculation.

Inability to make a voice contact with sample participants continues to be the primary obstacle to obtaining completed surveys. This includes participants for whom there is no valid telephone number, as well as those who are not home or do not answer the telephone. While the refusal rate is consistently around 20%, this figure is complicated by the fact that a number of participants are confused by the request. Of those who decline to participate, the reasons given include variations of "I don't have time," "I don't know what the MAPP program is," and "I didn't get the survey in the mail – send me another one and I'll fill it out myself."

Survey staff also field frequent requests for additional information about MAPP. These requests are always referred to an appropriate source, including the statewide toll-free telephone number and the name and number of the participant's local economic support office.

Recipient Survey Method

To reduce the paperwork burden to MAPP enrollees, and to reduce the cost of the evaluation study, the evaluation staff selected a random sample of enrollees for questionnaire mailing and telephone interviewing, rather than administering a questionnaire to all MAPP enrollees. The sample survey uses probability sampling to ensure that each potential respondent has a known probability of selection. This enables staff to give appropriate weight to each respondent so that the sample is representative of the whole population of MAPP enrollees over the course of the study period from December 2000 through January 2002.

Three distinct questionnaires were developed to measure MAPP impacts at three separate stages of program participation: the initial enrollment period, the period six months after initial enrollment, and finally, the time of disenrollment.

Target Population

At the outset of the evaluation, a working definition of the target population for the initial enrollment sample was "people within a few months of their first MAPP enrollment date". This definition is deliberately vague, because there was no pre-existing sampling frame to describe the population more precisely: the sampling frame had to be developed and adjusted over time as more people enrolled and more experience with the data recording system was gained. After learning the limitations of the data collection system, the evaluation staff are now in a position to firmly define the target population as "people within three months of their initial enrollment in MAPP between December 2000 and January 2002."

Three issues influenced the definition of the target population. One issue was recognized while planning the MAPP evaluation study: CDSD is simultaneously conducting another survey of some MAPP recipients. During the early stages of the data collection process, two unforeseen issues arose that required adjustments to the sampling method. The first issue is the length of time between a recipient's enrollment in MAPP and the availability of data that record the event, and the second issue is the definition of data elements related to MAPP enrollment dates.

Another research study currently in the field – Wisconsin Pathways to Independence (PTI) – involves administering questionnaires to some MAPP participants. Evaluation staff met with the PTI investigators and agreed to exclude people in their sample from the MAPP sample frame, so as to avoid excessive respondent burden. Since the degree of overlap is only about 11% of MAPP enrollees (45 cases out of a possible 398 to date), it is not expected that this will be a major problem. If time and resources permit, PTI investigators may be asked to provide aggregate descriptive data for their respondents to

compare with MAPP data to better judge whether this exclusion has significantly compromised the ability to generalize results to the entire MAPP population.

Sample Frame

The frame from which the MAPP survey sample was randomly selected is the Medicaid Recipient Operational Data Source (ODS), which contains a subset of Wisconsin Medicaid fiscal agent data stored in the Medicaid Evaluation and Decision Support (MEDS) data warehouse. The Recipient ODS contains eligibility and enrollment information that is updated continuously as Medicaid recipients begin or end their participation in MAPP and other Medicaid programs. Since MAPP is a new program, the administrative record-keeping system is also new, which requires a dynamic approach to sample frame construction as data processing procedures are developed and refined over time.

It was learned through experience that a lag of at least six weeks after a recipient's MAPP enrollment date must be allowed for record-keeping and data processing, before the most current enrollment data can be used for sample selection and questionnaire mailing-list construction. Also, there was initial confusion over the precise definition of fields on the MA Recipient database records that contained information related to MAPP enrollment dates. One field called "Eligibility Add Date" was used to select the first sample, but another field called "Eligibility Begin Date" was used subsequently since it was determined that the latter field more accurately records recipients' MAPP enrollment date.

This information influenced decisions about the frequency and timing of subsequent sample selection dates. Selection dates are now chosen to be at least six weeks after the first day of the month prior to the selection date. To ensure that all the samples represent the same target population, a firm definition of the sample frame for each selection date was established so that selection probabilities could be rigorously determined. The sample frame is defined to be "all MAPP recipient database records that have 'Eligibility Begin Date' between the first day of the third month prior to the selection date, and the last day of the month prior to the selection date, and that have not appeared in WPTI participant lists or in the sampling frames of previous selection dates."

Sample Selection

The sampling proceeds according to these steps:

1. Collect all MAPP recipient records from the "Recipient ODS Universe" in the Business Objects database where "Eligibility Begin Date" is prior to the last day of the selection interval (i.e. the selection date), and "Eligibility End Date" is after the first day of the selection interval.

2. Eliminate multiple records for each recipient, keeping the unique recipient ID number, the minimum (first, or earliest) "Eligibility Begin Date", and the maximum (last, or latest) "Eligibility End Date".

3. From this set of unique recipient records, keep those where the minimum "Eligibility Begin Date" is after the first day of the selection interval, and the maximum "Eligibility End Date" is after the "Eligibility Begin Date".

4. From this set of unique recipient records that fall within the selection interval, eliminate records of recipients that have been selected for the WPTI study, and eliminate records of recipients that have already been in MAPP sample frames of earlier selection dates. This yields the sample frame for the current selection date.

5. From the sample frame, randomly select a number of records so as to obtain a sufficiently large sample over the course of the study. The appropriate sample size is determined according to the formula:

   Sample Size = $Z^2(P\text{-}P^2)E^{-2} = n_0$
   Corrected Sample Size = $n_0/\{1+[(n_0\text{-}1)/N]\}$

with 95% confidence interval (i.e. Z = 5% two-tailed critical value of z-distribution = 1.96), 5% desired precision (i.e. E = error tolerance = .05), and 50% expected population proportion (i.e. P = most conservative value = .50), with a finite-population correction (i.e. N = expected total MAPP enrollees = 1500). The resulting sample size of 306 is then divided into monthly segments according to our judgment about the rate of new enrollment, expected total enrollment, and questionnaire completion rates.

Applying these definitions and procedures, the sample obtained as of June 12 for the Initial Enrollment Questionnaire consists of the following:

Month of Initial Enrollment	Number in Frame	Number in Sample
December, 2000	90	10
January, 2001	124	22
February	91	26
March	123	45
April	87	32
May	53	53

Six-Month Follow-up Sample

The study is a panel design, which will attempt to collect three questionnaires for each sampled MAPP recipient. For those recipients, the six-month questionnaire will truly be a "follow-up" of the first. However, rather than wait six-months to begin collecting data with the "follow-up" questionnaire, we decided to draw a random sample of MAPP recipients who had initially enrolled six months or more prior to the survey date. These recipients will receive the six-month questionnaire, and if they stop participating in MAPP during our study period, they will also receive the disenrollment questionnaire.

Applying these definitions and procedures, the sample obtained as of June 12 for the Randomly-Selected Six-Month Questionnaire consists of the following:

Month of Initial Enrollment	Number in Frame	Number in Sample
January-July, 2000	428	49
August	105	24
September	100	35
October	118	14
November	106	31

Disenrollment Survey

A MAPP disenrollment survey was also developed to capture information on causes of disenrollment from MAPP and whether or not the program met the participants' expectations. The disenrollment survey is mailed to a sample of disenrollees with a cover letter and postage paid return envelope. An attempt is made to complete the survey over the phone if it is not returned through the mail.

Disenrollment surveys are sent quarterly to a random sample of MAPP recipients who had disenrolled by the survey date, and to all recipients of the initial enrollment and six-month "follow-up" questionnaires, upon our receipt of notice of their disenrollment from the MAPP program. Random samples for the initial group of six-month and disenrollment surveys were chosen by the same methods used for the initial enrollment survey sample selection.

Applying these definitions and procedures, the sample obtained as of June 12 for the Disenrollment Questionnaire consists of the following:

Month of Disenrollment	**Number in Frame**	**Number in Sample**
January-July, 2000	14	10
August	8	4
September	12	8
October	12	7
November	15	10
December	35	24
January, 2001	25	14
February	21	14
March	49	29